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A Penal Administrator Looks at Psy[illegible]

James V. Bennett, LL. D.

Director, U. S. Bureau of Prisons

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Use of Authority in the Treatment of Delinquency

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INTRODUCING
THE JOURNAL OF SOCIAL THERAPY

This issue marks a historic point in the evolution of this publication. What has been the News Letter of the Medical Correctional Association now becomes the Journal of Social Therapy. Increased in size and elaborated in form and content, it signalizes the Association's growth, in membership and in collective professional devotion.

The Journal of Social Therapy is conceived as a broad-gauge, flexible implementation of the Association's basic aim: "to band together all those especially concerned with or interested in the medical aspects of crime." This declaration connotes a wide range of initiative and endeavor; to help marshal this enterprise by recording its course and indicating its projection, the Journal proposes:

To provide a forum for the dissemination of ideas, suggestions and the fruits of experience in our own and related fields;

To guide and clarify the variety of effort involved in the long-range purposes of social therapy;

To correlate current events and social trends in the zones of criminology, forensic medicine and therapies with our specific interests and objectives;

To review with informed objectivity the cumulative literature bearing or impinging upon our professional responsibilities; and

To chronicle the activities of the Association and its members.

The progress represented in this first issue of the Journal has been made possible by the loyal support and cooperation of the Association's members and its interested patrons; continuation of that progress will bespeak an extension of this collaborative zeal in an expanding scope.

In their current stage the Association's endeavors emphasize the hope of bringing more scientific enlightenment into the treatment of social offenders. Lingering remnants of retributive justice impose upon prison-bound therapy a task virtually equivalent to the introduction of surgery in a morgue. As the handicap of that archaic principle is progressively eliminated, we hope to devote more attention to the constructive, forward-looking objective of expanding and elaborating the multiple techniques of rehabilitative therapy.

The progress represented in this first issue of the Journal has been made possible by your loyal support and cooperation; its continuation will bespeak an extension of this collaborative zeal in an expanding scope.

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A Penal Administrator Looks at Psychiatry

By JAMES V. BENNETT

Director, U. S. Bureau of Prisons

It has been suggested that one in my position might be able to show from actual cases how the law and psychiatry could work together a little more effectively.

My situation illustrates the dilemmas we in the institutional field frequently have to resolve. We have to meet practical situations realistically and without stalling as they arise. We can't be too philosophical.

Not long ago, for instance, we received a man committed to us as being unable to stand trial because he had lost his voice. Following careful examination it was determined that he was unable to talk because he was so emotionally upset his voice had gone and his esophagus so constricted he had to be fed for a time intravenously. Following a course of psychotherapy he recovered, was taken into court, tried, convicted, and given a 15-year sentence. He has been occupying his time lately filing all kinds of complaints against us in the courts.

Perhaps he is no more to be blamed than was the prisoner who while awaiting execution was successfully operated upon for a strangulated hernia. He thought we should have let nature rather than the law take its course. I will not deny to each of you the right to have your own opinion as to the course to be taken, but as a lawyer I have to assume there was a possibility he might up to the very last minute escape the supreme penalty.

But that same situation sometimes arises in the mental field. What is our duty with respect to a prisoner who at the time of arraignment and indictment was perfectly competent to stand trial as he was at the time the crime was committed, but while awaiting trial becomes a mental case as a result of the long strain and worry over what was to become of him? Should we, assuming it a proper case, give him shock or other psychotherapeutic treatment and thus make him fit to stand trial? That is a hypothetical case, but we had one where the man was convicted of murder and sentenced to be executed. Between the date of sentence and execution he became hysterical and then obviously insane. The execution of the sentence was held in abeyance and later he recovered completely. He was referred back to court with the report that more than likely he would again relapse if the sentence was ordered into effect. After a great deal of consideration his sentence was commuted to life imprisonment.

We can have differing views as to the wisdom of that procedure, but not all cases are as grim or difficult. Let me tell you of a practical way in which we integrated law and psychiatry. A short time ago a young colored boy was committed to us for a minor offense. Later the police, through his fingerprints, developed the fact that he was engaged in some serious housebreakings. Meanwhile, we had learned that he was afflicted with narcolepsy. Whenever he was brought indoors and allowed to sit in a chair unmolested for three to five minutes, he fell asleep. He blissfully dozed off when he was brought into court for arraignment and it took a lot of poking to get him to stand up and mumble something, which the judge directed to be entered as a "Not Guilty" plea. There was no question but what he was sane, reasonably intelligent and knew the difference between right and wrong and we so reported to the court. But was he competent to stand trial? Now we brought about that highly desirable integration of law and psychiatry by stationing one of our attendants behind him in court and continually poking and jabbing him until the trial was over. It was a vivid demonstration that law and pragmatic psychiatry can act with celerity when necessary.

But these cases are simple and elementary compared to the difficulties presented institutional people and the courts and the psychiatrists by paranoid personalities. In the federal System we get quite a large number of individuals who write threatening and abusive letters to their real or imagined enemies. As you know, they are usually quite intelligent, make an excellent appearance in court, are plausible, usually pleasant until crossed and have none of the superficial characteristics of the mentally ill.

I have in mind the case of a 42-year-old man who was charged with sending scurrilous postcards through the mail. When the offender was originally arraigned in court the judge took considerable testimony from a number of psychiatrists, some of which was contradictory in nature but on the whole pointed to the fact that this man was incompetent. Accordingly, under provision of law, he was committed to us to be held until such time as we found him capable of standing trial. He had not long been in our custody when he filed a habeas corpus action before a different court, of course, than the one that committed him. Notwithstanding the unanimous testimony and conclusions of the psychiatrist, the judge made a finding that the lucidity of his testimony, his general demeanor on the witness stand and his evident intelligence created a strong probability that he was sufficiently restored mentally to be able to stand trial. The judge, despite the findings of the psychiatrist, ordered him returned to the trial court, which was in this case Los Angeles and 1,300 miles from the hospital where he was held for trial.

When he was again brought before the original committing judge, further testimony was taken as to his mental ability, a lengthy hearing held at which four psychiatrists testified who were unanimous in their opinion that the accused was psychotic. The court again held that it could not in the face of such testimony conclude otherwise than that he was insane. He held that in insanity proceedings it is necessary for courts to accept findings made by medical and psychiatric experts. As a result the prisoner has again been committed to us and he is once more filing habeas corpus petitions. No doubt the process will go on interminably, since we haven't any really good plan for bringing these conflicting courts together. Perhaps the only way we are going to be able to solve this problem

will be to contract for his care in a mental hospital in the same district in which the court originally holding him insane has final authority and jurisdiction.

But the point I want to make is that in the same case one group of psychiatrists was able to show the court the man was a mental case and another group was not able to convince a different judge of the wisdom of their findings. It means, of course, that judges differ and have differing standards as to mental responsibility, but it also drives home the point that psychiatry lacks definite standards, particularly on the right-and-wrong test. This is discussed in a most learned milestone opinion in Smith v. Baldi (192 Fed. 2nd, 540). There Judge Biggs tries to reconcile the psychiatrist's testimony that the defendant knew the difference between right and wrong but was unable to act accordingly. He points out: "The human mind, however, is an entity. It cannot be broken into parts, one part sane, the other part insane. The law, when it requires the psychiatrist to state whether in his opinion the accused is capable of knowing right from wrong, compels the psychiatrist to test guilt or innocence by a concept which has almost no recognizable reality."

I commend the case to you. It's a splendid discussion of the whole issue.

Now I want to turn from this case, which seems to indicate the need for a more consistent policy on the part of the courts and the need for psychiatrists to be more specific and make their diagnoses more certain and clear, to one where the psychiatrists seem anxious to create a high nuisance value for men like me who are low on the totem pole.

I know it isn't necessary for me to dwell on this long-debated problem of integrating psychiatry to the courts by the development of a common and understandable language. The judges don't go to medical school and the psychiatrists don't go to law school, I know, but it ought to be possible to make them understand each other a little better. Here, for instance, is an excerpt from a report that one psychiatrist wanted me to present to the court: "The Szondi Test findings in summary indicate: (1) Immature ego development with attempted repression of forbidden sexual impulses, (2) An overt manifestation of oral character traits with likelihood of strong oral sadistic trends, (3) A person whose libido still remains strongly attached to the primary object. The conclusion was that 'we are dealing with a chaotic personality displaying many somatic symptoms and complaints and anxiety features and his hold on reality is quite tenuous at this time.'" Interestingly enough, following a period of observation and deep coma, he was found to be oriented in all spheres and classified and later determined to be able to stand trial.

It would be much better, in my judgment, not to make any report at all to the courts at the initial stages than to give the judge the mumbo-jumbo that was at first suggested here. But the courts, on the other hand, are anything but understanding of the problems of the psychiatrist. They have a feeling apparently that the psychiatrist can look at a patient and give him a few simple tests and come back with a report in a few hours or the most a few days. One judge became very disgusted with us because we wanted thirty days in which to develop our report. Another judge wanted a categorical statement from us as to whether a certain sex deviate would respond to treatment. We had to duck this one, as you can readily appreciate.

As a matter of fact, probably the area in which there is the widest difference be-

tween the courts and the psychiatrists concerns the sex offender, the feeble-minded and the senile. I haven't a case that combines all three of these elements, but I have several that combine at least two of them. For instance, I know of a feeble-minded Negro, coming from a broken home and with parents who were both seriously delinquent. This man had a long history of robbery, assault and frequent arrests for sodomy. At the age of 18 he entered an apartment and attempted to sexually assault a woman. Incidentally, he took along a knife and an ax to protect himself, so he claimed. He was found to be, as a result of these charges, a juvenile delinquent and was, because of his assaultive and bizarre behavior, committed to a mental hospital. But at the hospital they said he was not legally insane and bounced him back to us to handle as a juvenile delinquent.

Upon the completion of his full sentence he was discharged, as required by law, and almost immediately he sexually assaulted two women and was again brought into court for trial. The testimony showed that, while considerably below normal in intelligence, he did know the difference between right and wrong, that he was basically a psychopathic personality with pathologic sexuality. The court, in this instance and with such a diagnosis, could do nothing but convict him under the usual procedure and he is now serving a sentence of 7½ to 22½ years. Assuming that he lives to complete his full sentence, which seems altogether probable, what can be done to protect the community against him? Certainly, he is not going to recover, because even now, after five years in prison, he takes delight in recounting his exploits. Do the psychiatrists have any answer to this problem?

One of the most conscientious judges I know asked me to give him an opinion of a middle-aged homosexual offender who had been molesting young boys. He had vigorously denied his guilt, but after conviction by the jury confessed to the judge that he had actually done the things of which he was accused, but begged to be released on condition that he submit himself to the care of a psychiatrist. The judge wanted to know what the possibilities were for treatment and whether he would turn out to be a menace to the community if he were granted probation. He also wanted to know specifically the names of institutions in a position to treat such a case. I had to report that the only hope for changing an obsessional drive of this kind was probably deep psychoanalytical treatment, which we were informed cost about $1,000 a month. This was an impossible sum for the defendant to raise, even if the treatment offered more than rather remote hope for complete recovery. We had been asked specifically what we recommended by way of treatment. It was a first conviction for this particular offender and the judge did not feel that he could in good conscience commit him for a long number of years, since he was in all other respects a reputable member of the community and a successful businessman.

What we did was to suggest that he be given a short period of institutional treatment, and if he showed signs of understanding and a willingness to cooperate with the psychiatrist he would be recommended for parole and be closely supervised in the community. Perhaps in the present state of the knowledge of this problem that's all we can do, but the point I am trying to make is that before we can hope for closer integration we must have more definite answers to such problems.

It's hard to pick out which are the most baffling of our unsolved problems. But since the recent prison riots have focused

attention on these institutions and not a little criticism has been aimed at their managers for not preventing outbreaks of the kind that took place recently at the tremendous institution at Jackson, housing upward of 6,500 men, let me tell you about the case of Earl Ward, the young man who triggered the Jackson revolt.

At the age of 16 Ward was arrested in Philadelphia for turning in a false alarm. As an incorrigible he went to an industrial school from which he twice ran away. Later he was transferred to the reformatory at Huntingdon, where he was tabbed as "having no chance of ever making good." The prime effort apparently was to make him "do his time" because he was later transferred to Pennsylvania's new institution for young offenders at White Hill near Harrisburg. Notwithstanding his participation in a desperate escape attempt, during which another boy was shot, he was discharged two years after his original commitment. There followed a series of stolen car incidents, a period of observation in a Pennsylvania mental hospital, a bout with heroin, and a quickie marriage, following which he ended up in a Michigan prison serving fifteen to thirty years for a robbery that netted him $100.

There followed a prison career of destruction, assault and serious maladjustment, ending in complicity with "Crazy Jack" Hyatt in a plot to "blast out" of prison with Governor Williams as a hostage and shield. Doubtless he looks forward, as the prisoners phrase it, to "doing life on the installment plan." Here was a product of the streets of Philadelphia, run through a fruitless gamut of custodial treatment in Pennsylvania and turned loose to be a charge upon the people of Michigan. The damage of $2,000,000 he is alleged to have triggered should bring home the necessity of finding a better way.

The proposal of the American Law Institute that the courts be granted authority to sentence such individuals to indefinite periods seems to be the only way out. Under this proposal the court can in its discretion give such individuals an indefinite sentence and require that periodically the case be brought back for further study to determine whether the offender will be continued in custody. Such a system in effect is in operation in California for all offenders, and under the Youth Correction proposal is in operation in a number of other states. This law has in effect been recently incorporated into the Federal law. Certainly the day must be near at hand when we can substitute a more flexible procedure for the present system of definite sentencing, at least in certain types of cases.

If this is done, it will of course require an extension of psychiatric service to the courts. No laymen, frequently no psychiatrists, can on the basis of the facts usually before the court say whether a particular individual is a psychopathic personality of the type who needs to be kept under observation for a long span of years. The answer to the problem must be found in closer relationships and confidence by judge and psychiatrist alike. Moreover, machinery must be provided whereby the courts can commit such individuals prior to sentence to a diagnostic clinic for report. If they are found to be a continuing and potential danger to the community, they should be committed indefinitely to an institution having means to follow up on them and, when cured, authorized with the permission of the court to release them. Perhaps some such system as that may not be too far distant. New Jersey already has a diagnostic clinic, but only for a few selected

cases and merely for the purpose of giving views to the court on the prisoner prior to final sentence.

I would like to speak my piece concerning one other matter that is a more or less constant source of annoyance. It's illustrated by the case of a young man committed to us by the Army for assault and molesting young children on an Army reservation. The case has all the stigmata, as you psychiatrists would put it, of the sexual psychopath. But this young man's family refused to accept the diagnosis and are demanding his release on the ground that he was unjustly convicted and that his sentence was far too long. In addition to hiring some high-powered legal talent, they have employed a psychiatrist. This psychiatrist is loudly clamoring for opportunity to examine this young man and contends that he can determine on the basis of a two or three-hour interview whether the diagnosis of the other psychiatrist is accurate. We have furnished him with a complete record of the man's case, the findings of the psychiatrist and given him access to the trial record. Naturally and logically, he contends these are insufficient and claims that if he could have a short interview with the prisoner he would be able to reach a final and definitive conclusion. Needless to say, we believe that this is all veneer to help him support the finding he has already reached that the young man is not dangerous to the community. Such tactics, we are inclined to believe, are not in accordance with the best interests of psychiatry.

I hope we are at the beginning of a closer relationship and more frequent discussions between lawyers and psychiatrists. I know that there are an increasing number of lawyers who are anxious to gain a broader understanding of the basic reasons accounting for certain offenses. Like doctors, lawyers are becoming more and more specialized and there are all too few who have the time to represent adequately an indigent and mentally twisted defendant. But their reverence for the law and their determination to bring it abreast of modern behavior sciences makes them avid for knowledge and light on this difficult subject. The psychiatrists can, by making themselves available to bar associations, judges and courts, do much to stimulate this most desirable objective, and perhaps out of such meetings will come a mutuality of understanding that spells greater justice and further and steady improvement in our democratic institutions.

The Use of Authority in the Treatment of Delinquency

By ESTHER BOYD BROMBERG

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The purpose of this study is to discuss the treatment of 17 delinquent girls whose destructive behavior in a California Youth Authority school in March, 1953, attracted nation-wide attention. My account of their brief detention and care at the state hospital following the riot raises several questions regarding the handling of delinquents which deserve continual exploration and consideration. First, what is the meaning and character of authority from the viewpoint of the young person separated from home and society for alleged misconduct? Second, what is the nature of the group relationship among disturbed adolescents, and to what use may this relationship be put in a therapeutic program oriented on individual problems?

These 17 girls were a segment of a school population of 200 who in a few hours destroyed $5,000 worth of windows and damaged other property in the Youth Authority School, roamed the grounds, fanned out into adjoining communities, defied authorities and were finally rounded up, some going to jail to be later committed as an emergency measure to nearby state hospitals for 90 days' observation. The 17 who came to our hospital were under sedation, handcuffed and looking only a little less distraught than the puzzled deputy sheriffs who escorted them.

Lurid newspaper accounts and radio bulletins preceding the arrival of the girls had informed us of explanations offered by the school authorities for the riot and helped to create the impression that a new species of social monster might have been spawned. Explanations in the press were indicative of the confusion of the community. Some of the girls, said the authorities, had not been at the school very long and had not been well studied, and coming as they did from the southern part of the state, were in some way accountable for the riot. Allegedly homosexuality was rampant at the school and this, far from being denied by the a u t h o r i t i e s, was excused as being "characteristic of a d o l e s c e n t girls in groups."

The physician in charge of admission and I decided on a hastily contrived plan of treatment. We adopted an attitude of therapeutic optimism and were determined

that the period of observation was to be a constructive experience for the girls. Several characteristics of authority that we considered indispensable were help and support when trouble strikes, familiarity with the problems of adolescents and protection of them from further difficulty. The oft-repeated words of the doctor to other young people who had been committed to the hospital as unmanageable were, "We are sorry you got into trouble, but since it happened we are glad to have you here and to help you make something of yourself."

From the outset the doctor enforced her orders and hospital regulations with a vigilant sense of obligation, to the patient and the institution. From the moment of arrival the presence of strict authority was felt and re-experienced at each instance of infraction of rules or indifference to the comfort and welfare of other patients or when there was discourtesy to ward personnel. Strict control was interpreted to the girls as being in their interest and for their protection. Clarification of this important aspect of authority minimized much anxiety and established a good basis for approaching the group on deeper levels.

During the first ten days after admission the girls were completely in the hands of the physician. They were observed closely and an estimate made of their potentialities for accepting their immediate environment. They were allowed to visit with each other freely on the ward, but retired early to separate rooms in the evening. As far as practicable, the unity of the group was respected and the girls were removed from the gaze of the curious, They ceased to be a subject for news copy. After the ten-day period of adjustment, I began group interviews. Later and as often as indicated I saw individuals in personal interviews. None of the girls was able to talk freely in a personal interview until after she gained confidence in the worker as a result of group meetings.

There were three girls aged 13, six aged 14, three aged 15 and five aged 16. Ten, including one full-blooded Indian, were natives of California and seven had been born in other states. There were three white girls, eight Negroes, four Mexicans, one Indian and one of mixed blood. Ten girls were Catholics, seven Protestants. Almost all attended church. With two exceptions, the families fell into low-income and dependency cases.

Six girls were of average intelligence, four of low average, six borderline and one was at a high moron level. All were low in scholastic achievement and all disliked school.

Statistically, five of the girls' homes could be considered intact. Actually, only two were so organized as to be properly considered unbroken. The others contained varying degrees of delinquency which occasionally separated members of the family. In one the father was engaged in an extramarital problem involving a child born to a woman in the community; in a second home a delinquent older sister had been in a reform school and in a third the father was in jail for drunkenness.

Six homes were those of mothers who had borne the girls out of wedlock. Four of these were Negro girls, one was the child of a white mother and a Filipino father, and the sixth was the Indian child whose family lived according to tribal customs. In the case of the half-Filipino girl, the mother was an alcholic and the father had been in prison after killing one of his countrymen for being intimate with the mother of the girl. The mother finally married a third Filipino who was at this time

a good stepfather. One Mexican girl had an aged and intolerant father. One case of illegitimacy was a girl who was one of three out-of-wedlock children her mother had borne by different men.

In six instances where the girls were of legitimate birth there was known sexual irregularity among parental figures, although there was but one illegitimate offspring. One importance of transgressions of a sexual nature was the bond it appeared to make between sexually experienced girls in the group and between the girls and their mothers when both were sexually unconventional. There was much less criticism of these mothers than there was of mothers who were virtuous and who suffered as spouses of philandering fathers. In almost every case the heavy use of alcohol by fathers and stepfathers was recorded and resented.

The girls as a group were children from homes where asocial attitudes and conduct were long-standing problems and who therefore had almost lifelong experience of a potentially disturbing nature.

Group meetings were held from the beginning because individual interviews were anxiety-producing. Earlier experience of the individuals with adult figures caused "clamming up."

The girls individually recognized their situation and asked not to be interviewed without some of their friends present.

The first group meetings induced an outpouring of apprehension, uncertainty and disappointment. The girls were dismayed and unhappy that their misbehavior at the school had resulted in commitment to a mental hospital, an experience for which none was prepared. Because the girls felt they were in a precarious situation and expressed fears of being railroaded, I described how, working together, they might make a good record and thus convert an unpleasant situation into an opportunity for understanding how the course of events had developed as it did.

The nature of their infantile thinking and dependency needs was illustrated in the girls' vaguely expressed idea that the riot was an effort to break restraints that kept them from their mothers. They felt that they somehow should have been sent home instead of to a mental hospital. Lack of judgment was further evident in the unreserved description each girl gave of her role in the riot. I got the impression that all felt a kind of fateful or preordained quality in the outbreak of hostilities, something akin to a tornado for which they could not be held accountable although they could recall how it had enveloped and moved them chaotically until they were taken into custody. Some had not taken part in the riot but had been gathered up in the fray or because they were in the vicinity of friends who had broken windows or otherwise contributed to the disorder. Lack of guilt was not the most significant factor in resenting hospitalization, though all were proud to show their solidarity with those who had been active participants. The most obvious attitude was the positive feeling of justification. All disparaged the newspaper accounts and belittled widespread charges of homosexuality. They said there were a few girls in the school, not in their group, who were talked about in this respect. Several expressed great disgust for alleged homosexual conduct.

All gave precisely the same explanation of why the riot occurred: that two very popular girls in the school had been taken away secretly and their disappearance had become known a few hours before the eve-

ning meal at which the riot was precipitated. Discussion of this incident revealed the unconscious feeling of group loyalty. Although the girls removed had been sent to a state hospital, the group would brook no excuse that this removal might have been for the girls' good or in the interest of the school. The girls' friends treated the incident as though it were the action of secret police operating in the dead of night.

The group described their individual feeling of resentment at learning that the girls had been removed. They boiled all day and, upon entering the school dining room for the evening meal sullen and resentful, they went to their tables. One girl, instead of sitting down, impulsively pushed her table, overturning it with a clatter of dishes and screams of surprise from the girls. This action started a chain of events which resulted in more tables being overturned, overflow of the noisy disorder into passageways and dormitories, the breaking of windows to free girls in detention, breaking of more windows to show cooperation and unity until the majority of the school was involved in uncontrolled aggression against the building and its furnishings.

The signal was clearly an impulsive, unplanned act to which none was party but to which all responded. Each girl described the same uneasy feelings, pent-up emotions, accumulated irritation, boredom and total absence of any idea of doing anything about their situation or feelings until they perceived the sudden opportunity. At the time of interview all felt the riot was inevitable and justified. Even those who were least dissatisfied with the school admitted b r e a k i n g a few windows and milling around the grounds and feeling the satisfaction of expressed resentment.

Group cohesiveness in the school and for a while after hospitalization was further indicated and strengthened by a language of words and signs, much of it expressive of vague undifferentiated feelings of being disfranchised and not open to understanding by adult figures. All girls at the school were called "chicks." Some were called "daddy." There were some "mommies," but these were not necessarily related in each instance to "daddies." These terms did not have a true sexual implication. The "daddy" was more of a mentor, an experienced inmate who knew her way around in the institution and administrative situations and could function in a protective and advisory capacity to new or backward girls. The term "crybaby" indicated a relationship wherein two girls could lament and complain to each other. The use of foul language was marked. Many adult figures and their actions as authoritative persons were referred to as excrement. All trouble was referred to as "messing up."

It was in the area of sign language that the girls reached a real insularity. By glances, grimaces and various innocent-appearing positions of hands, signals were given and attitudes struck, particularly in the face of an adult figure. In early interviews, before rapport and trust were established, a too trusting remark by a girl was quickly silenced by a move following an expletive to attract attention. I employed the opportunity in these instances to agree with the group that silence might be appropriate and that they were right to be self-protective until they felt sure of themselves and of me.

The adolescent need to be rejecting and to feel rejected was obvious. Lacking insight into their primary problem because it was overlaid with so much external reality material, these girls, with little talent

and less opportunity for intellectualizing and verbalizing feelings and experience, were naturally very dependent upon each other for emotional support. They had become delinquents because their first natural efforts to assert their initiative as individuals were technically and legally asocial and plunged them headlong into the hands of the juvenile authorities. Although running away from school and home were legal offenses, the girls experienced these actions as a necessity in the face of home and school circumstances and as purely personal business. The concomitant distress and deprivation, in reality banishment from their mothers, being more clearly perceived by them than their delinquency, made purely authoritative figures appear like a combination of robber and turnkey. No positive values were sensed or experienced at the hands of juvenile authorities except friendship with each other, dictated by circumstances and emotional deprivation. All the girls used the phrase "locked up" to describe experience in local detention homes and time spent at the Youth Authority School.

It is evident, then, that this adolescent group constituted a social microcosm with its own dynamics and laws of operation. It is clear also that in this exquisite fact is found the **status nasciendi** of the riot. The removal of the two girls from the school group was a wound inflicted on the collective ego. Through the breach tumbled a torrent or unconscious, seemingly aimless aggression. It was symbolic that nearly every window in the school was pushed out. What these children seemed to say was that if society could not perceive their state of emergency, did not know that the school was a disaster area, the victims would come rushing out with much noise and complaint and make known their needs.

The most general and oftenest repeated complaint against the school was alleged racial prejudice. The girls made much of evidence they had sighting the proscription of the Spanish language, the renaming of two dormitories that had had Spanish names, and attributing to the Spanish-speaking Mexican girls a relationship to the Pachuco groups (adolescent marauder gangs) of ill-fame in Los Angeles. Negro, white and Mexican girls joined in denunciation of the school authorities and the expressed conviction there was a slight to subcultural groups. They sneered at the taste of the authorities who would not hire Latin-American or Negro dance bands for school dances. With characteristic childish capacity for picking out the weakness of adults, they said anyone knows it is better music than the Western or hill-billy bands employed.

Recent studies of the cause of the riot have failed to substantiate racial prejudice as a major contributing cause. The complaint must then be viewed as a result of a mistaken effort of school authorities to modify a specific characteristic of a group because this characteristic was misinterpreted as a causative agent. The measures intended to break down the patterns of behavior were viewed as attacks, as insult, as robbery and experienced as an intolerable ego injury. The result was the further consolidation of group loyalty, heightening of resentment against authority and sharpening of the critical sense. Such an error on the part of the school, due to lack of knowledge of behavior problems, is nevertheless regrettable as evidenced by the riot and the resulting confusion in the public mind of the real problems back of the riot. The same report which minimized racial prejudice and homosexuality as problems

ended by recommending "greater use of psychiatric sash." Psychiatric knowledge or study was not recognized as a need of the institution.

When the authoritative figures have missed the essence of a child's problem, they are apt to cover by making a myriad of inconsequential rules. This is what happened at the school. Although the girls had no insight into the problem of authority at bay, they characterized the numerous prohibitions as "silly." There were rules against black clothing because it was worn by Pachucos; rules covering how to comb hair—"no piling high on the head on weekdays, only on Saturday, Sunday and holidays;" when to wear earrings and whether to wear bobby sox high or low and the proper length of skirts in relation to the style of bobby sox. There was to be no rattling of candy bags at the movies in the school auditorium, where if there was too much of this and too much laughter a matron appeared on the stage and, standing in front of the screen while the movie was on, admonished the girls to quieter demeanor.

The girls' recitation of rules and prohibitions gave the impression that the students had no direction along positive lines. They had a great deal of advice about what not to do and none which established standards of value, correct demeanor, or suggested what we call norms. Regimentation of even a mild degree is doomed to eventual failure if it does not prepare the individual for freedom and active participation in community management. Regardless of the length of time the girls had been in the school, none had ever been called into group conference nor had there ever been a school assembly when the thinking, feelings, wishes or options of the girls were asked. There was thus no consultation with the community being governed. One also gained the impression there were no prototypes of social behavior in the school.

Einstein has said, in relation to another mystery involving control, "If you listen to nature she will tell you her secrets." If authority would listen to children they would tell their needs and intentions. A recurring phrase among these girls was "cut out." This was their lingo to describe escape of any kind—truancy, running away from home, eloping from detention homes, absenting themselves from classes, any avoidance of being where they were supposed to be. The frequent use of this phrase, together with the manifest satisfaction of relating instances of "cutting out," properly interpreted, could have served as a warning that a mass break was in the making if not actually imminent.

Further evidence that these girls found nothing positive in their handling by juvenile authorities was their attitude toward their experience after being made wards of the juvenile authorities. They looked back on life before they were apprehended and looked forward to release. The interval between these events was called "doing time." The already well-established fact that adolescence cannot tolerate being imprisoned and immobilized without serious traumatization is reaffirmed in the case of these girls.

At the hospital there was no difficulty in the early establishment of a good relationship. There were vehement protestations that none was "crazy" and that they did not belong in a "bughouse." They readily accepted reassurance on this score. However, about the seventh time I went to see these girls on the ward, I found them droll and uncommunicative. They were, as usual, huddled together and holding themselves aloof from other patients. This coalesced

hostility developed at the end of the third week and occurred on the security ward where the greatest amount of attention was given. The girls, d i s g u s t e d with everything, suddenly seemed unable to understand the hospital and thought they could not remain through the ninety days. Some of the personnel mistook this episode of despair and emotional retardation as a danger signal and feared plans of elopement.

Anticipating a negative attitude, I prepared a lesson for the occasion when it developed. I fell back on simple but imaginative creative teaching techniques and gave as interesting and convincing an account of the hospital as I could. The goal was to meet misgivings of the girls by giving them, in answer to their questions, a sense of their relative position and importance in a community that implied responsibility on the part of authority and recognition of patients' rights. This meeting was, to the girls, apparently impromptu and informal in the sunyard of the ward and was conducted like a classroom lesson hour with the exception that I, as usual, brought cigarettes.

I allowed this pause, dictated by resistance, and employed the time with an unexpected lapse from more intensive handling of feeling. A constructive manner of seeing is infectious and the young are susceptible to those who claim them with resoluteness and interest in their welfare. The group responded with appreciable relief from doubt as to the meaning of their detention. Although they were limited in intellectual ability and precipitately confronted with mental illness, they seemed able to grasp the reasons for their detention and to feel that by virtue of their assigned tasks, they were part of an institution that was socially and medically important.

From this juncture on many of the girls were better able to assume work assignments on the ward and to be, in most cases, a little more understanding. Once they could drop their worry about where they fitted into the scheme of their environment, they were able to move to a consideration of their own fundamental problems and behavior. In s u b s e q u e n t meetings they turned to the subject of their mothers and home relationships, their numerous stepfathers, and to sexual problems. Ventilation of feelings of anxiety about sexual behavior resulted in the expressed conviction that the therapist understood their problem. Questions involving medical judgment were referred to the physician.

Among the 17 girls, 13 admittedly had been initiated sexually. Later they discussed their sexual experience with the doctor and reported their relief at having the matter handled medically. The doctor had avoided both c r i t i c i s m and permission. She explained that older people criticized and tried to prohibit sexual behavior because the girls were so young and because they were not married. Paraphrasing her, as they did when reporting their satisfactory interview, they said she had told them that when they were 18 or were married even though younger, no one would think their sexual activity was wrong.

As the girls became adapted to the hospital environment, restrictions eased and recreation on and off the wards was permitted. Group cohesiveness waned after about two months' hospitalization and the girls became more involved with their individual problems. There was more interest in vocations, an understanding that they were individuals and that they had responsibility in the matter of adjusting socially. Two of the girls had been assigned to duty on the female sick ward, where they were

much appreciated for their cheerful discharge of assigned duties. Singular praise for excellent performance brought home the lesson to each of the group. Evidence of the value of being in a meaningful environment was indicated by the large number of girls who became identified with the ward attendants and expressed the wish to become nurses. Some phantasied how well they would look "all dressed in beautiful white uniforms with white caps."

The construction of a new body image was one of the important developments. A girl who envisioned herself in a nurse's uniform was one who had suffered much from attracting unfavorable attention from male figures. Liking herself in a uniform was a great step for this girl whose need for attention lay deep. However, there was for the most part a minimum of preoccupation with personal appearance, except for social activities where male patients participated.

Some of the girls were purposefully assigned to assist in the administration of electro-convulsive therapy. The doctor's analysis of the value of this experience was that adolescent groups are thoroughly experienced in visiting aggression on each other. She felt, therefore, that observing the therapy would not be intolerable or damaging to the girls, but would afford them an experience in seeing force directed against human beings under controlled conditions for therapeutic reasons. The result was as impressive and beneficial as had been anticipated. Those assigned to the duty, although not actually necessary, felt they had been privileged and made important.

Authoritative figures in the hospital setting were more satisfactory than in the school because they were protective, accepting, optimistic and informed. These qualities of authority made it possible to involve the group and finally the individuals in a therapeutic plan in which they could establish their function as individuals in a meaningful environment. Psychotherapeutic measures endowed authority with purpose and gave personal problems a new relative importance having little to do with cultural differences and social status. Meeting the group situation with acceptance and support gave authority the p r e s t i g e of strength, which relieved feelings of helplessness, which in turn often lead to panic reactions.

The character of a group is determined by its emotional needs. In the case of disturbed adolescents the dependence of individuals on each other is due to unsatisfactory childhood experiences with their sexual prototypes and the hazards all human beings feel in the passage from childhood to adulthood. The chasm of adolescence is more terrifying to those who have not had preparation for meeting this crisis. When parents have failed to be dependable and consistent in the early life of the child and when they are still inadequate during difficult adolescence, children bind themselves to each other in regression and rebellion. The weak ego structure of deprived adolescents is sensitive to every slight, real or imagined. Unable to stand alone, these children band together, isolated by their own confusion and afflictions. Having committed themselves to each other for mutual protection, they dare not chance the loss of identity involved in a trusting relationship with adults in whose eyes they feel they appear weak and dependent.

The untreated individual disturbed adolescent will relate to authority only at what he considers his optimum advantage which

is in his group. This is his conscious recognition of his unconscious needs. No approach but that of helpfulness and understanding of the loneliness of the adolescent is fruitful for either the diagnostician or the therapist. The maturation difficulties of a human being are not disease processes for which a specific label must be found before a remedy can be applied. The doctor is no greater aid to nature at the birth of a child than he is when the young adult is emerging into his outer world. Here therapeutic optimism and professional prestige are both medicine and nutriment. Impressions:

The magnitude of the social offense is not the measure of the individual's pathology or his ability to respond to psychiatric help.

Development of the individual may be speeded by early competent treatment and perhaps brief periods of therapy. A few weeks of treatment in the hands of a competent psychiatrist in a meaningful setting may be of far more benefit than years of imprisonment in a large institution.

Segregation and expensive installations may be but an expression of society's guilty wish to eschew responsibility for genuine care of disturbed children.

The complexity of the problem of human development implies that disturbance of personality must be handled by a physician. Institutions, even for allegedly mild disorders in behavior, should be under medical supervision.

Adolescent behavior problems are complex. Parents cannot be expected to bear responsibility for treatment. The reasons for underlying conflicts spring from parental patterns and problems, hence another agency is necessary to reduce the outgrowth of these circumstances which surround children.

Treatment of the Social Offender

By EDWARD C. RINCK, M.D.

Director, Medical Center for Federal Prisoners, Springfield, Mo.

Every tree that bringeth not forth good
fruit is hewn and cast into the fire.
Matthew 7:19.

I appear before you as one who has spent fifteen years of his life in the correctional field, in the hope that prisons, as correctional institutions, can become increasingly efficient as treatment centers for the rehabilitation of the criminal offenders. Last year Professor Clyde B. Vedder, Criminologist, University of Florida, appeared before this organization, speaking on the counter-forces in prison inmate therapy. The picture he drew was indeed a gloomy one, as he spoke of all the various factors in prison which tended to foredoom any effective treatment program. In all honesty, I must admit that many of the barbs levelled at the present-day prison system are all too true. However, are we as ready as a former mentor of mine to say that the prison is no longer necessary and that, except for a minority of hardened criminals in whom there is no hope of rehabilitation, the prisons and jails should be emptied?

I am afraid that society will continue to insist for some time that we continue to have prisons. I feel equally certain that society will more and more insist that prisons do an increasingly better job at returning to its ranks former social offenders who are ready to take their place as social conformists.

Finally, I believe very definitely that professional penologists have the knowledge, methods and tools whereby some social offenders can be successfully treated. However, before such treatment programs become commonplace certain things will have to be accomplished.

FIRST, although modern classification of prisoners as to treatability has been practiced since the early thirties, limitations imposed by lack of sufficiently diversified institutions has prevented the accomplishment of ideal classification. Except for an occasional rare institution, most prisons must of necessity continue to house the hopeful and the hopeless social offender together. No psychiatrist would think of placing a young schizophrenic in a ward with chronic deteriorated schizophrenics and hope to achieve any degree of success from his treatment. Similarly it should be self-evident that, no matter how excellent the treatment program of the prison, it will

be ineffective in the presence of the untreatable hardened, recidivist social offender.

SECOND, the personnel of the successful treating prison will have to be oriented to their individual roles as participants in a therapy program. Psychiatric hospitals at one time thought of treatment solely in terms of what the psychiatrist had to offer the patient. The sub-professional personnel played varying minor roles in the treatment program, but without any insight as to what the psychiatrist was attempting to accomplish. Came the period after the war, and recognition was made that the treatment program was missing a good bet by not fully utilizing the potential power for treatment encompassed in the sub-professional personnel. We then witnessed intensive training programs with attempts being made to acquaint the sub-professional personnel with the nature and character of mental disorders. They were taught the meaning of the various symptoms which the patient utilized. Most important, they were taught the significance of hostility and how it should be handled, etc. The sub-professional personnel then for the first time recognized that their role in the treatment program was a very important one.

The story is told of a veteran suffering from chronic schizophrenia being brought to the local Veterans Administration office with the request that he be given hospital care. He was sent to an excellent Veterans Administration Hospital in the midwest. There he was treated by a staff committed to the idea that a "total push program" would help patients suffering with chronic schizophrenia. The patient was helped and in due course of time had improved to such a degree that it was possible to release him to his family. This patient was so grateful for the treatment accorded him that he stopped off at the Veterans Administration Office to thank them for having sent him to the hospital. The amazed officials, so surprised by the improvement attained in a case which they considered hopeless, inquired of the patient just what had been done to effect such an improvement. The patient then stated that for the first time in his life, he had been allowed to tell the story of his illness. He was then placed in the care of so many people who seemed to be so concerned about his getting well that he had no alternative but to get well!

I am convinced that if all our professional and sub-professional personnel in our prisons were oriented as to their responsibility in the treatment program for the social offender, we would have a much more efficient treatment program than now too often prevails.

THIRD, I should like to see more extensive utilization of newer treatment techniques adapted to larger numbers of inmates. Group therapy at this time appears to give promise of being such a technique. My own experience with this new form of therapy has been somewhat limited, but I am convinced from what I have seen of it that it has some virtue as a medium for changing men's attitudes.

Alcoholic Anonymous Chapters are now prevalent in most of our institutions and have as their objective the changing of attitudes toward drinking. The modus operandi of this organization is essentially group therapy. I do know from observation that participants in Alcoholics Anonymous group meetings do appear to have changed social attitudes. The members tell me that something has changed, that they can't exactly describe it, but for the first time life has a definite meaning for them, that they are more contented and more

tolerant of their lot in prison. In fact, this phenomenon has been witnessed by non-alcoholics and they have requested permission to participate in A. A. meetings: I do not know whether it is still true, but at the last time a survey was made, in no instance did any member of A. A. participate in any of the riots which have plagued our prisons the past couple of years.

If the principle of group therapy works for an appreciable percentage of alcoholics in changing social attitudes, why won't it work in changing attitudes for our social offenders?

FOURTH, I think that it should be recognized that prison incarceration is but one phase in the treatment of the social offender. Also participating in the treatment program are the police who first apprehend the criminal, the court which decides on the duration of the treatment, and finally the Probation Officer who often supervises the social offender after his release from prison.

Very few persons, other than those who have taken the route, have any concept of the amount and degree of hostility developed by the average offender as he first comes into the hands of the police and then passes over into the jurisdiction of the court. The unfortunate aspect of the whole matter is the tenacity with which most offenders cling to their hostility and how they transfer it very readily to those in charge of treatment at the receiving prison. In fact, it is the existence of such universal hostility, present in varying degrees in the social offender, which is the most discouraging factor to the therapist in the prison situation. Many therapists experiencing this factor of hostility for the first time have declared that successful treatment is impossible in the prison situation. Admittedly, it is a formidable matter which does threaten the success of any treatment program. However, in my opinion it is not insurmountable.

Much better, of course, would be the situation if those agencies having relationship with the offender prior to his admission to prison could be acquainted with this situation and attempt to minimize it. At present it is safe to say that none of the governmental agencies mentioned has much understanding of the interrelated problems of the other. Although I have seen a few probation officers in prison, I have seen but one judge and no police officers! We in the prison situation hear so many complaints about the law-enforcement agencies and their methods that we often identify with the inmate in objecting to them, while having no actual knowledge of their methods. The courts come in for their share of criticism as not giving the offender the right decision or for being unjustly harsh. The Probation Officer is described as being unsympathetic, as not recognizing the realities of life or unwilling to give the releasee help when he most needs it. The prison also is often pictured quite unfavorably to all the various agencies I have named.

Would it not be in the best interests of the social offender and society if a mutual understanding of the common problem could be acquired by an occasional conference of all agencies concerned with the ultimate fate of the social offender?

These represent random thoughts concerning a problem with whose solution all of us are concerned. The prison is the tree, if you will permit. If it is not bearing good fruit, then there is justification in hewing it down. However, I contend that it can be made to bear good fruit if properly tended.

Prison for Mental Defectives?

By GERTRUDE KOSKOFF

Member, House of Representatives, State of Connecticut

Thousands of helpless people today are in prisons in America who should not be there. These people are being punished as criminals, when in fact they are not. They are mentally defective and feeble minded, and the proper place for them is mental institutions.

Deplorably, such people are being sent to prisons every day because there is no other place for them, or because it requires too much red tape to have them committed to overcrowded, understaffed mental institutions. Often there is no place to hold retarded persons until the formalities of a committment are completed, so for the sake of convenience they are sent to jail. The shocking fact is that too often they remain there.

Many are the victims of injured brains, some from birth, others resulting from later injuries, convulsions or from high sustained fevers of some childhood illnesses. The brains of these delinquents are damaged in such a way as to make them unaware of what they are doing.

Such was the case of 18-year-old Billy Rupp of California, sentenced to die for the murder of a young girl. In a letter to Gov. Goodman Knight, the boy's sister told of severe convulsions Billy suffered as an infant. The results of these spasms were recently discovered by scientific tests of his brain waves. It was the area of Bill's brain that controlled the inhibition of animal impulses that was damaged. With such an impairment Billy could not possibly control his actions.

Dr. Oreste Hood of Los Angeles, recently quoted for his work with the brain-injured said, "To punish a brain-injured delinquent is like punishing a blind boy for stumbling." There are as many as 2,500,000 brain-injured in the United States. "Much can be done to help these people," says Dr. Tracy Putnam, of California, neuro-surgeon, who is famous for his contributions in the study of epilepsy, "but if they become involved in delinquency and are sent to reformatories and other prisons, they are truly lost."

Dr. Putnam tells of another boy who compulsively stole cars. Upon examination he was found to have abnormal brain waves. After a course of intensive treatment for epilepsy he completely recovered from his delinquent tendencies and was saved from a life of crime and imprisonment. This boy never had the usual convul-

sions that characterize epilepsy. He could easily have been diagnosed as a criminal and punished for something over which he had no control.

At the Western Psychiatric Institute of the University of Pittsburgh, the following incident took place: A young woman was repeatedly in trouble with the police for snatching items from store counters. Because of headaches, she was referred to a prominent neuro-surgeon, who presented her at a staff conference. While being questioned, she lost contact with the environment, picked up the doctor's bag and started toward the door. A few moments later she regained consciousness and had no recollection of having taken the bag. She behaved just as a person does under hypnosis. A brain-wave test revealed that she was suffering from a form of epilepsy that was causing this uncontrollable pattern of behavior.

Had this girl been sent to a reformatory for stealing, who there could have diagnosed her real trouble? Surely her anti-social behavior could not be considered in the usual moral and legal sense as defiance of law and authority. No amount of punishment could change habits she could not control.

The tragedy is that many such persons may not be recognized as defective by the courts and are sent to penal institutions by mistake, but it is a serious indictment of our penal and humanitarian principles when people known to be mentally defective are deliberately sent to prison. Not only are they sentenced from courts, but in some states defenseless patients are transferred to reformatories and jails from mental institutions. This happens when they become "too difficult" for management to handle.

Minnesota passed a law in 1945 to make such transfer possible, with the excuse that the mental institutions were overcrowded. This law does not provide that these patients commit a crime or even be delinquent. No trial or hearing is necessary. When an institution wants to rid itself of "troublesome" patients, a request for transfer by the Director of Public Institutions is all that is required.

This was a practice in Massachusetts for years until cases like that of Wilfred Besner were recently exposed in an investigation by Attorney General Fingold. Besner spent 30 years in prison without a hearing or trial until a month or so before he was released. The judge reviewing his case declared he never should have been sent to jail because he had never been convicted or even accused of a crime. He had been transferred from a Massachusetts institution, which had tagged him "defective delinquent," because he had attempted to escape several times. He was sent to the Bridgewater State Farm, and later to Concord Prison, where he remained under an indeterminate sentence. He would still be in prison had it not been for the probing into these cases by the attorney general. A Massachusetts law enacted in November of last year made it necessary to review all cases of defective delinquents in prisons in Massachusetts. Most of those in jail were there, as Wilfred Besner was, without due process of law.

In Connecticut, since 1939, a law has been on the books permitting the transfer of feeble-minded patients from mental institutions to reformatories for "vicious tendencies." The patient need not commit or even be accused of a crime to be transferred. A normal person could not be sent to jail for a "tendency." He would first have to commit a crime. According to this law, medieval as it seems, not crime but feeble-mindedness is punishable.

Because of a technicality, this law has never been enforced. But for a period of four years another law, which permitted

transfers from the training schools for the mentally retarded to the state reformatories, was in effect in Connecticut. In 1945 this law, very much like the old Massachusetts law under Governor James McConoughy, was repealed.

Despite this repealed law, a bill was introduced at the last session of the legislature that would have overcome the technicality and implemented the old '39 Connecticut law. It failed to pass the Senate and this problem was turned over to the State Legislative Council for further study. Their rocommendations will be presented at the next session of the General Assembly.

This bill was opposed by several psychiatrists of the Yale Medical School and one among them, Dr. Richard Karpe, submitted the following statement: "Any psychiatrist, who instead of requesting improvement of his psychiatric set-up, recommends the transfer of his patient to a prison is open to suspicion that he feels punitive toward the patient because he has not responded to treatment as expected."

Dr. Seymour Sarason, Associate Professor at Yale, and formerly a psychiatrist at the Connecticut Southbury Training School, for the mentally retarded, says: "My major impression is that the transfer of feeble-minded and defective delinquent patients to penal institutions does not result in any benefits to the patient. I think that such transfer is a highly punitive step which in no way corrects the problems which gave rise to the behavior necessitating the transfer."

It is true that the patient with delinquent tendencies poses serious problems within an institution for the mentally retarded. He is often a bad influence and takes advantage of patients who are not delinquent. Many times he needs more security than is usually provided in mental institutions, to prevent him from escaping and getting into mischief in the community.

In Connecticut such patients escaped from the Mansfield Training School and set fire to barns at neighboring farms. Certainly the public must be protected from such hazards, but no effort has been made by this institution to make the facilities more secure, either in a separate department within the training school, or in a separate mental institution. Instead, much energy has been exerted by this training school to transfer these patients to the Connecticut State Reformatory, where they would be confined in cellblocks, without any psychiatric care.

Leonard Comstock, Superintendent of the Connecticut State Reformatory, said it was impossible for these retarded boys and men, transferred from mental institutions during the four years the law was in effect, to adjust to the staff or their fellow inmates at the reformatory. Nor could they adjust in the training departments, or to the program in general. Their presence was a disruptive influence, which severely hampered the program for the other inmates.

Mr. Comstock told of one of these transferred boys who periodically picked up anything he could grab from the dining room table and hurled food and dishes into space. This boy made several attempts at suicide and was found with his bed sheet wound around his neck almost strangled to death. The reformatory had nothing to offer such a boy, obviously in need of psychiatric care, but iron bars and an opportunity to learn more about the ways of delinquency and crime. Surely improvement or reform could not be hoped for by placing him in a cellblock.

All agencies interested in their welfare are opposed to handling the mentally retarded in prisons. Dr. R. H. Felix, director of the National Institute of Mental Health says: "We

understand why some state training schools do not want defective delinquents, while on the other hand we believe the prison system is less able to cope with them. The psychiatric implications in these special behavior problems are considerable, and I doubt if any penal system can handle them satisfactorily."

James V. Bennett, Director of the Bureau of Prisons under the U. S. Department of Justice, says: "In those states where there is not a separate institution, the defective delinquent group could be more effectively treated under the state hospital program, since these persons should be under medical supervision."

A meeting of the Society on Mental Deficiency in New York was told of the serious problems of handling the defective delinquent in the same program with the mentally retarded who are not delinquent, by Dr. Arthur E. Westwell, superintendent of the Montana State Training School. However, he pointed out that patients are often erroneously tagged "delinquent" by management who wish to rid themselves of difficult patients whose problems rightfully can and should be handled in a mental institution.

It has been proved that the energies of this type of patient can often be channeled in ways that will prevent him from becoming delinquent. Dr. Israel Zwerling, on the faculty of the University of Cincinnati, has had much experience with this problem and cites one typical example: Angelo, aged 19, at Letchworth Village in N. Y., training school for the mentally retarded, fought with everyone, broke windows, attempted escape several times and would not cooperate with the program in any way. After careful examination of psychological tests made on him, the laboratory director of the institution offered to take him under his wing and try to occupy him in any useful way he could. Gradually Angelo became interested in the work. Under the sympathetic guidance and encouragement of Dr. Zwerling, he earned the title "laboratory assistant." He cleaned test tubes, mixed stock solutions, fed the laboratory animals, helped with autopsies and did minor electrical maintenance work. This boy became the most useful patient at the institution.

Dr. Zwerling believes Angelo's chances for making an adjustment to society are good, but with prison experience those chances would have been greatly diminished. A person already mentally unsound is less able to withstand the emotional strain of circumstances brought about by imprisonment and it is almost certain that he will become worse in a penal atmosphere.

Ten years of statistics at Sing Sing show that ten times as many people develop insanity in prison as in any other community in the United States. Many others, although they do not become insane, are hopelessly d a m a g e d. Nevertheless, the brain-injured, m e n t a l defectives, feeble-minded, psychopaths, the insane and those considered normal are committed indiscriminately to the same penal institutions and thrown together. It is impossible to conduct a program of reform with such a variety of inmates who are incapable of reform, and can only become worse through punitive measures.

This circumstance is a large contributing factor in prison riots. The American Prison Association has found that the ringleaders are usually mentally unsound and incapable of weighing the consequences of their actions.

Earl Ward, the leader of Michigan's Jackson Prison riot, was twice adjudged insane. At the time of the riot, 100 prisoners were insane, and 200 others had been in the mental wards, but had been released to the regular cell blocks until such time as they might again become too difficult.

A survey of 10,000 men at Sing Sing revealed that 35 per cent of the inmates were psychopaths, 20 psychoneurotics and 15 per cent mental defectives.

Dr. Ralph S. Banay, formerly psychiatrist at Sing Sing, warns that the committment of such people to penal institutions is wasteful of human material and dangerous to society. He urges the screening and separate psychiatric care of mentally ailing and defective offenders, as he says locking up their bodies protects society only until their release from jail. They are then turned loose, unequipped to handle themselves, with a criminal record as a further handicap. It is inevitable, and surely the records prove that they get into trouble again, and are often a grave menace to society.

The daily newspapers are full of accounts of the tragedies brought about by the mentally deranged who have long prison records. The recent murder of a little girl in Hartford, Conn., who was choked to death by her own scarf at the hands of Robert N. Malm, is such a case. His police record is a long one. Society had its chance more than once to prevent this tragedy.

For such serious symptoms there should be an indeterminate sentence, with concentrated psychiatric care, until such time as the patient is cured. If the patient is released, he should then be under strict and skillful parole scrutiny.

Dr. Banay reiterates, in his several publications in the study of these matters, that were such offenders immediately screened for mental disorders, and given psychiatric care instead of useless punitive treatment, much tragedy could be prevented.

The absence of special facilities for the testing and handling of such offenders is bound up with the lack of facilities for mental disorders generally. The cry is for economy, but losses to society and innocent families by preventable crime are immeasurable. F.B.I. Chief J. Edgar Hoover estimates the cost of crime as 20 billion yearly. The money wasted keeping people, who can never learn by punishment behind bars, releasing them, and again returning them to bars, might well be spent instead in the pursuit of preventing such crime.

C. R. Cass, Secretary of the American Prison Association, says: "Screening to separate the mentally defective from criminals is essential for public welfare. Concentrated psychiatric attention, rather than a punitive program, is of the utmost importance for the practical handling of this type of offender, whether young or old. The record shows he comes back to prison over and over again. Obviously the punitive system does not work."

The International Penal and Penitentiary Congress held at The Hague in the summer of 1950 with representatives from the U.S. and countries all over the world adopted a resolution, which embodies the idea of screening and segregating feeble-minded and persons with abnormal personalities from criminals for the purpose of proper psychiatric treatment. They further resolved that this was necessary for safeguarding property and lives of innocent people.

Many states do some screening before sentencing, but it is usually at the discretion of the courts. Should the judge think that the accused is mentally unsound he orders an examination by a psychiatrist.

The number of defective people overlooked by the courts can be estimated by the many mentally ailing and defective inmates populating our prisons. The District of Columbia reports that 22 per cent of the prison population is mentally defective. In Mississippi it is 30 per cent, in Connecticut

18.6 per cent. These are figures for only those whose intelligent quotients are under 70. They do not include the psychopaths, psychoneurotics and brain-injured.

Judges and lawyers are not trained to detect mental defects, and so a large percentage go unrecognized through the courts into prisons.

It should be part of regular court procedure to have criminal offenders, and especially those with previous records, scientifically examined for mental disorders. There should be a clinical staff of adequately trained people to do this testing and diagnosing. Proper mental institutions are sorely needed to treat those who should not be sent to prison.

Delaware, in recent years, with an alarming increase of mental defectives and psychotics committed to their prisons, now practices a more enlightened system of presentence investigation. They have also built a separate department at the Delaware State Hospital for the care of these people.

Maryland has gone further than Delaware and has established separate units, in which different types of abnormal offenders can be segregated, observed and given proper psychiatric treatment. They have found from experience that it is impractical to throw all types together in the same program.

Much research is needed to determine the causes and proper handling of the abnormal offender. The State of New Jersey, a few years ago, recognizing this need, erected a modern clinic for the thorough study of this problem.

Ohio, since 1948, has made much progress in these matters, and by 1955 will have in operation a reception and classification center where defectives will be screened from criminals.

Connecticut has recently completed a survey on prisons and penal problems. Recommendations for the screening and segregation of criminals are being considered for the next legislative session. Last spring representatives from Connecticut, at a meeting of the Council of State Governments in New York, discussed the possibility of establishing one mental institution for the care of the defective delinquent to be used jointly by the six New England states.

All of these advances are brought about through legislative action. Legislative bodies, to a great extent, decide the fate of these unfortunates. State representatives, senators and assemblymen pass or reject laws which send these helpless people to jails, and they appropriate or refuse money for institutions and adequate facilities for their proper care. Unfortunately, the legislators too often fight these issues out among themselves without expression from the public. When this happens decisions are sometimes governed not by principle, but by political pressure. In such important matters, the public should be interested enough to make its feelings felt by the legislature before action is taken.

There are nine million people in the United States who suffer from mental disorders. This is about 6 per cent of the present population, or about one in every 16 persons. When some of them become involved with the law, it is more often than not the result of mental defect or retardation and social incompetence rather than a desire to be anti-social. If they are treated as penal problems and deprived of medical care and denied the benefit of advances in psychiatry, their chances for ever becoming independent and useful citizens are very slight. It is much more likely that they will become permanent burdens on society.

Conflict of Evidence

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In the realm of forensic psychiatry, perhaps no single topic has provoked more discussion than the conflict of psychiatric evidence, particularly in criminal cases. Notwithstanding this discussion and various solutions which have been advanced, the conflict continues in many jurisdictions: certainly in the United States and Canada, the spectacle of psychiatrists testifying for the prosecution that an accused person is mentally competent, conflicting with psychiatrists testifying for the defense that the same accused person is mentally incompetent, is all too familiar.

This conflict of evidence has ramifications beyond the trial of the individual offender. Some lawyers are apt to conclude that psychiatric testimony is a commodity to be purchased by the highest bidder; courts may lose confidence in psychiatric evidence; the public may lose faith in the integrity of psychiatrists.

Why has this situation persisted? Is it inevitable? Is there anything psychiatrists can do to abolish or diminish the conflict of psychiatric testimony in criminal cases?

The suggestion that the root of the problem is the venality of some psychiatrists is contradicted by the experience of psychiatrists who are experienced in court work. Most psychiatrists in this field can recall cases where their opinion has been unhelpful to the lawyer requesting the opinion. These psychiatrists are not called to give evidence (with a loss or reduction of fees); the fact that they gave an adverse opinion does not become known.

Honest differences of opinion arise in psychiatric practice, just as they arise in other branches of medicine. When such differing psychiatric opinions are expressed in court they do not warrant a finding of venality on the part of psychiatrists any more than in the case of conflicting evidence by surgeons, radiologists, engineers, handwriting experts or other kinds of expert witnesses.

In analyzing the causes of the conflict of evidence, attention must be given to the prevailing legal procedures whereby the mental illness of an accused person is tested. The law in Canada is similar to that of the United Kingdom and the United States (except that the doctrine of "irresistible impulse" which has been adopted by some states does not exist in Canada).

Briefly stated, an accused person may plead that he is unfit to stand trial by

reason of insanity, or he may plead that he was insane at the time the act was committed. In the latter event, the issue is governed by the McNaghten rules. The procedure is that counsel for the accused person calls one or more psychiatrists to testify for the defense; the prosecution calls one or more psychiatrists to rebut the evidence for the defense.

It is obvious that counsel will seek out psychiatrists who will give helpful testimony, helpful, that is, to the side which calls the witness. Honest differences of professional opinion are likely to be exploited and magnified. In the atmosphere of the trial, a psychiatrist is apt to become a protagonist for the side which called him and to stress in his evidence those symptoms which support the position of counsel who has retained the psychiatrist.

The root of the conflict of psychiatric evidence is to be found in the honest differences of professional opinion which do arise in the practice of psychiatry and the likelihood of the exploitation and magnification of these differences in our system of jurisprudence.

The unhappy results of this system in some cases have led to recommendations for change. Some of the recommendations have been adopted. The following is not an exhaustive list.

(a) **The Briggs Law.** This Massachusetts statute is known so widely that it needs no recapitulation. From published reports of its operation it appears to have been successful in achieving its objects, one of which was the elimination of conflict of psychiatric evidence.

Notwithstanding the success of this statute in its native state it cannot be assumed that it would of necessity achieve the same results in other jurisdictions. For example, the selection of the examining psychiatrists by the state government may be satisfactory in Massachusetts, but might be subject to abuses in other jurisdictions. Also, psychiatrists who examine an accused person under such a statute are required to express an opinion as to criminal responsibility in terms of the McNaghten rules, in the states where these rules are in force. This is true of most of the United States, Canada and the United Kingdom.

(b) Non-statutory use of state psychiatrists.

The Briggs Law provides for the mandatory use of state psychiatrists. Some states make available the services of psychiatrists employed by the state: their evidence is available, without fee, to the prosecution or defense. It cannot be said that this procedure has been entirely successful in eliminating a conflict of evidence (in the areas with which the writer is familiar).

(c) Hospital examination of defendants.

The literature contains accounts of the experience of some states and provinces which provide for the mental examination of an accused person in a psychiatric hospital. The advantages of this arrangement are apparent to psychiatrists. The extension of the procedure may be limited by the fact that some areas run into constitutional difficulties in providing for the legal sanctions and by the fact that it is an expensive arrangement.

(d) Miscellaneous law reforms

Under this heading, may be reviewed a number of law reforms which have been put forward from time to time.

(i) Nomenclature

The American Psychiatric Association is on record as advocating the adoption of modern terminology in the statutes governing mentally ill people, not only in civil law but also in criminal law. Terms such as "insane," lunatic, idiot and imbecile"

should be replaced by words such as "mentally ill, mentally defective." Some objection may emanate from "stand-pat" jurists on the ground that the case law and judicial precedent which have been built up on the old terminology might be inapplicable to the new descriptive terms. Most provinces of Canada have enacted these changes in their civil statutes and representations have been made to the federal government to make the same revision in the criminal law. The changes have not occasioned any judicial consternation.

The arguments for change are not only humanitarian: a signal advantage is that psychiatrists are able to express their evidence in the terminology which they use in practice rather than in the stilted and archaic terms of a bygone era. The consequent gain in clarity tends to reduce the likelihood of a conflict in psychiatric evidence.

(ii) **The panel of experts**

From time to time, recommendations are made to the effect that the present system whereby psychiatrists are called as witnesses for the prosecution or defense be replaced by a "panel of experts." There are variations on this theme, for example, that the panel be appointed by the judge, by the chief law enforcement officer (Minister of Justice, Attorney-General, etc.), by the Department of Health or similar state department; that the panel report be in writing and not by oral testimony; that there be no cross-examination; that the jury be dispensed with.

The principal defect in this type of recommendation is that it fails to take into account some elementary principles of jurisprudence. The recommendation as worded is often one which could not be fitted into the administration of justice without careful consideration and modification.

The object of these recommendations is clear and may be meritorious, but there is need for collaboration with the legal profession in order to formulate a plan which is legally sound.

It is certain that in most jurisdictions there will be an insistence upon retaining those legal principles which are fundamental in safeguarding the rights of an accused person. The right of an accused person to have his guilt or innocence determined by a jury is fundamental. The right to trial in open court, where witnesses appear and are subject to cross-examination, are of paramount importance.

Any method of adducing psychiatric evidence must be in accordance with these fundamental rights.

It may be possible to evolve a satisfactory solution by reserving psychiatric evidence until after the guilt or innocence of the accused has been determined. In other words, psychiatrists would not testify until after the accused person has been found guilty: psychiatrists would then testify as to the existence of any mental illness which would be relevant to the sentence.

Any such plan would require careful study by bar associations or similar competent legal bodies inasmuch as it would involve the introduction of certain concepts (particularly the concept of diminished criminal responsibility) which are not presently a part of the criminal code in most jurisdictions.

(iii) **Psychiatric Treatment in penal institutions.**

A number of writers have reported upon their experience in the use of the psychiatric treatment of offenders who are serving sentence in penal institutions. On the whole, however, few penal institutions are able to provide psychiatric services.

The limitation of these services is probably due in part to the difficulty in securing the necessary money, but difficulty is

also experienced in securing trained personnel. There is a natural reluctance on the part of psychiatrists to devote themselves permanently to an occupation in which they are likely to be isolated from their professional colleagues.

This is undoubtedly a field of psychiatric endeavor which will expand. Psychiatrists will be consulted individually and through their organizations in the course of this expansion. In these consultations psychiatrists can perform a valuable service in insuring that the work which is conducted in penal institutions is so devised that the results are available for publication and thus for the guidance of others entering this field in the future. Psychiatrists may also be able to influence the administrative arrangements so that the psychiatrists employed in penal institutions are connected with psychiatric centres and do not become professionally isolated.

Discussion.

While these remarks were being compiled there appeared in the press a short account of the findings of the British Royal Commission on Capital Punishment (Globe and Mail, Toronto, Sept. 24, 1953). In these recommendations, the Commission included the following:

"The commission also said that the present rules under which a plea of insanity must be disregarded if the murderer knew what he was doing and knew that it was wrong had brought the criminal law into disrepute.

"It is well established that there are offenders who know what they are doing and know that it is wrong, but nevertheless are so gravely affected by mental disease that they ought not to be held responsible for their actions.

"It suggested that the current rules be enlarged to include as insane this type of offender or that they be abolished and the question of whether the accused was so insane as to be criminally irresponsible be left to the jury."

From the foregoing report it would appear that the issue of insanity as a defense would continue to be left to the jury, which would perpetuate the unsatisfactory arrangements regarding the conflict of psychiatric evidence in these cases.

The Commission sat for more than four years and doubtless assembled authoritative views from many sources, yet it is unlikely that the recommendations of the Commission, without other changes, would remove all of the existing criticism. This is another illustration of the difficulty at arriving at a uniform, universal solution.

Summary

It is suggested that, in moving to achieve a solution of the existing conflict of psychiatric evidence in criminal cases, psychiatrists individually and collectively are more likely to achieve their objective by acting wherever possible in concert with lawyers and legal associations in order to integrate proposed changes with the prevailing system of jurisprudence.

Some of the topics which would lend themselves to this type of joint discussion have been reviewed. Some topics which are suitable for early implementation are: extension of psychiatric facilities for the courts through statutory or non-statutory use of state psychiatrists and the hospital examination of defendants; the revision of the terminology in criminal statutes governing mentally ill people; increase in psychiatric facilities in penal institutions. As a longer-term objective, it is suggested that consideration be given to a more drastic alteration in the criminal law whereby the issue of insanity is dealt with after conviction by a judge in determining the sentence.

Use of the Minnesota Multiphasic Personality Inventory in Measuring Adjustment of Prisoners

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It has been recognized for a long time that within a society, or even within a group, there are some individuals who can obey and follow those rules and taboos most commonly accepted in that group or society, while for others this is impossible. It has been stated that the latter do not form a psychologically or psychiatrically homogeneous group, but that psychiatry and psychology can help explain their behavior, termed "social maladjustment." This axiom for many years has been particularly applied in the study of criminals, and various theories, from the extreme constitutional to the extreme psychological, have been put forward to explain criminal behavior.

However, all the different theories were found to be applicable to only a minority of the so-called criminals and thus more confusion has arisen as to what forms the basis of criminal behavior. More recently, with the advent of genetic-dynamic concepts in psychiatry, the importance of the diversity and multiplicity of factors causing criminal behavior — somatic, constitutional, psychological or even sociological—became increasingly recognized and the necessity for a multidimensional attack on this problem was stressed. To this end, genetic research, sociological studies, clinical and laboratory investigations, electroencephalography and psychological tests, to name a few, have proved to be extremely helpful, and will prove to be still more helpful in the future to understand individual criminal behavior as a "bio-psycho-social" phenomenon, a term introduced by Lafon.

With the advancement of clinical psychology, various psychological tests have been devised which, when given to persons, would give a clue to their behavioristic and personality tendencies and would then enable the examiner to prognosticate to a certain degree the future personality development of the individual. The application of these tests has been mostly limited to so-called normal groups and mentally ill persons, while very little study has been done dealing with the personality makeup of already established criminals confined to penal institutions. It is true that from a psychiatric viewpoint the criminal has been considered as either a psychoneurotic or a psychopath, depending on the training and prejudice of the individual examiner, but the specific personality factors which might

be common to a great many if not to all criminals have not been elaborated on, as far as we were able to ascertain.

Thus, in a previous study, the outstanding personality factors among the population of a state penitentiary were reported. This study, as is the present, was based on the Minnesota Multiphasic Personality Inventory (MMPI). The MMPI is one of the tests described to measure personality factors and is easily administered and easily interpreted. It is a psychometric instrument designed ultimately to provide in a simple form scores on all the more important phases of personality.

In an attempt to assess the various phases of the total personality, groups of statements have been devised to which "true," "false," and "cannot say" responses may be given. The profile consists of various scales, including Hypochondriasis (Hs), Depression (D), Hysteria (Hy), Psychopathic Deviate (Pd), Masculine and Feminine interest (sex, Mf), Paranoia (Pa), Psychasthenia (Pt), Schizophrenia (Sc) and Hypomania (Ma). In addition, there are question and lie scores which measure the degree to which the subject may be attempting to falsify his score by purposely choosing the responses that places him in the most acceptable light in society. Also, there is a so-called K score, which represents the correctional factor. The number of cards sorted by the individual into the "true," "false," and "cannot say" categories are tabulated on a simplified record sheet that provides the basic record to be scored by any one of the various keys. The various profile scales, although named according to the abnormal manifestations of the symptomatic complex, have all been shown to have meaning within the normal range.

In the presentation of the results of the tests, the usual procedure is to translate the raw score of the measured traits into a standard or T score and plot them on a profile chart. This procedure permits analysis of the relative strength of the various phases, the pattern of which is often more important than the presence of any one phase to an abnormal degree. One important fact to remember on this test is that a standard score of 50 is average and every 10 points above or below represents one unit of standard deviation from the norm, and standard scores above 70 are definitely considered indicative of rather serious personality defects.

One of the conclusions of the aforementioned study was that among criminals one deals with a group consisting primarily of psychopaths and not with neurotics or psychotics. This study also revealed that the personality profiles of criminals convicted for crimes of violence and for sex crimes differed from those of criminals convicted of non-violent crimes; that recidivists showed a markedly higher psychopathic deviate peak than first offenders; and that the personality profile of the escapee differs from that of the non-escapee.

In a subsequent study electroencephalographic tracings of prisoners were correlated with their personality profiles as revealed by the MMPI, and it was shown that there are two main types of transgressors of the law who have reached imprisonment for totally different, almost opposite reasons, and as was concluded, should from every point of view have different treatment.

The first group consisted of the so-called psychopathic deviates as shown by their repeated collisions with society and their inability to resume responsibility in any community; these, according to the tests used, showed characteristic profiles on the MMPI, namely, a high Pd peak and had a

high incidence of normal EEG records containing chiefly pure alpha activity. Such individuals, it was concluded, because of their fixed personality pattern, without obvious psychological disturbance, require permanent maximum custodial care.

On the other hand, the second group contained mainly those who scored a normal or neurotic profile on the MMPI and they usually consisted of the lesser offenders against society. These had a higher incidence of abnormal EEG records. The unstable 4 to 6 per second wave forms and dysrhythmia in their records may indicate, as was concluded, an underlying relative instability of personality which is usually associated with any one of several dynamic categories other than the fixed personality pattern. It was then stated further that these subjects deserve careful therapy, both somatic and psychological, directed at their specific, underlying psychopathology.

In the present study an attempt was made to utilize the MMPI in determining the adjustment of the individual prisoners within this same state penitentiary, and to apply, if possible, this practically in predicting social as well as psychological adjustment of the individual prisoner, from his personality profile.

MATERIAL AND METHODS

Three hundred consecutive male admissions to the Washington State Penitentiary at Walla Walla, Washington, regardless of age, race and crime, were used in this study, most of them having been in the penitentiary for several years at the time of the test.

The group form of the MMPI was given and the results were plotted on the profile chart and the average profile was obtained for each group. All statistical errors and deviations were already eliminated when the T score for the individual was calculated, since the T score represents a statistically modified raw score. In comparing the mean group profiles, the statistically desired 5 per cent level of significance was determined by means of the "T" test for the significance of a difference between arithmetic means derived from non-correlated samples.

Institutional or social adjustment was divided into three main categories: good, fair and poor. This was determined from reports of the prison personnel and from the official prison records in regard to anti-social behavior and violation of the penitentiary rules. If there were no rule infractions or no anti-social behavior recorded, the adjustment was considered good; if minor rule infractions occurred, such as stealing food, arguments with officers, disobedience, etc., the adjustment was classified fair; and finally, if there were major rule violations such as rioting, fighting, the possession of weapons, escape attempts, the use of drugs or alcohol, etc., adjustment was considered as poor.

The psychological or psychiatric adjustment was also divided into good, fair and poor. This was determined from the verbal and written reports of the medical, psychological and psychiatric staff. It was considered as good if there was no evidence of psychosomatic disorders or overt neurotic symptoms; as fair, if there was evidence of neurotic mechanisms, such as nail biting, enuresis, moderate sexual abnormalities or overt psychosomatic disorders; as poor, if frank psychotic episodes occurred or if there were marked sexual abnormalities of a compulsive type present — conditions which necessitate immediate transfer to a state hospital for psychiatric attention.

Correlation was attempted between the age groups of the various prisoners, on the

one hand, and their psychological or psychiatric adjustment on the other. As was the case with the length of sentence, no trend could be found indicating that the psychological or psychiatric adjustment is dependent on a certain age group, with perhaps the exception of the 16-20 year old group, especially in regard to sex, a fact which has been explained previously. The psychological or psychiatric adjustment is again independent of the age of the prisoner, but dependent on his individual personality profile as shown on the MMPI. In other words, it is not dependent on the Pd scale, but dependent for those making a fair adjustment on the neurotic scales such as Hysteria, Hypochondriasis, Psychasthenia, etc., and for those making a poor adjustment on the Schizophrenia and Paranoia scales.

The total group of 300 prisoners was divided into first offenders and recidivists, their respective MMPI profiles charted, and their adjustment correlated. This, however, revealed again the already familiar trend, namely, that the higher the Pd scale the poorer the adjustment, regardless of whether the individual is a first offender or a recidivist. This, by the way, was confirmed by results of the former study, which showed that the group of recidivists had a higher Pd scale when compared to the group of first offenders. The statistically significant 5 per cent level was again found between the well adjusted and poor adjusted group, on the one hand, and the fair adjusted and poor adjusted group on the other hand, while no statistical difference was found between the good and the fair adjustment groups.

Finally, a correlation was attempted between the types of crimes and the social adjustment, the latter being again divided into good, fair and poor; and the former arbitrarily divided into non-violent crimes exclusive of sex crimes, violent crimes exclusive of sex crimes, and sex crimes, as such, both violent and non-violent. Again it was found that prisoners with a low Pd scale, regardless of the crimes they committed, made a good adjustment; those with a moderately abnormal Pd scale, regardless of the crime committed, a fair adjustment; and those with a markedly abnormal Pd scale, regardless of the crime committed, a poor adjustment. The findings of the former study, namely that the personality profile of the so-called sex criminals and the violent criminals are very similar but quite distinct from that of the non-violent criminals, was confirmed. The statistical difference was again found between well adjusted and poor adjusted; and fair adjusted and poor adjusted, but no difference was found between well adjusted and fair adjusted.

As far as the psychological or psychiatric adjustment is concerned, this was found to have no bearing on the fact whether or not an individual prisoner is a first offender or a recidivist; and was also found not to have any bearing on the types of crime he committed, but was dependent on the individual profile shown, especially in regard to the neurotic scales and the Schizophrenia and Paranoia scales.

SUMMARY AND CONCLUSION

The results of the present study are in substantial agreement with findings of the former studies and represent a confirmation thereof. The former studies dealing with outstanding personality factors among the population of a state penitentiary, and the relationship of the electroencephalogram to the personality profile as seen on the MMPI, indicated that one deals with at least two separate, distinct groups among inmates of a state penitentiary; one that

shows a high psychopathic deviate on the MMPI profile and corresponding definite electroencephalographic patterns; while the other shows normal or neurotic profiles on the MMPI and a distinctly different EEG pattern.

The former studies also indicated that prisoners who showed a high or abnormal Pd peak on the MMPI have an extremely poor prognosis — intra- as well as extra-institutional — while those whose Pd scale is within normal limits have a good prognosis, both within and without the prison. Thus, all three studies taken together, and especially the findings of the present study, appear to us to have great practical value and great implication for arranging a proper prison classification and custody assignment as well as for planning proper parole and predicting parole prognosis.

Although we are aware of the difficulty of obtaining sample data representing the universe of criminals, and the fact that offenders in custody are not n e c e s s a r i l y representative of all criminals, and that a sample of the general population is likely to include a proportion of undetected as well as future offenders; the group used here seemed to us large enough, and the findings so definite, especially since confirmed by the five per cent level of statistical significance, that several conclusions seemed justifiable.

The results of this study show that the greatest significance should be attached to the Pd scale within the MMPI profile. This is particularly important in regard to social or institutional adjustment of prisoners, since it shows a definite statistically significant correlation between the Pd scale and the type of social or institutional adjustment, especially between the good and poor adjustment groups and the fair and poor adjustment groups. The fact that throughout this study no statistically significant difference was found between the good and fair adjusted groups clearly points to the artificial and rather subjective distinction into these two groups, since among the fair adjusted groups only prisoners with minor rule infractions were placed, infractions which were not brought to the higher prison authorities and which were usually based on the complaints of individual officers. Thus the subjective attitude of the individual guard was extremely important in this respect and it can be readily understood that if an officer showed some favoritism to a particular prisoner he would not report a particular minor incident, while on the other hand if his attitude toward a particular p r i s o n e r was unfavorable, he would make a mountain out of a molehill.

It is thus felt that this artificial and subjective distinction and the designation of a fair adjustment group should be dropped, since no practical and statistical significance can be attached to it. On the other hand, however, as was pointed out, there is a practical as well as a statistically significant difference between the good and poor adjustment groups—a trend that holds true throughout this entire study. The higher the Pd scale, the poorer the institutional prognosis of the prisoner in regard to adjustment, a fact of great importance when assigning a type of custody to a prisoner.

This study also revealed a very important finding in regard to the social adjustment within the prison when compared with the length of sentence. Although the percentage of well-adjusted prisoners decreases as the length of sentence increases, this was not found to be of too great importance; most important, however, was again the Pd scale on the MMPI profile. In other words, the well-adjusted prisoners, regardless of the length of their sentence, were always found to have a normal Pd scale on

the MMPI; the fair adjusted prisoners a slightly abnormal Pd peak; and the poor adjusted group a markedly abnormal Pd peak, which was again found to be of statistical significance.

This implies that the length of sentence is not responsible for the social adjustment or maladjustment of the individual prisoner, but that it is his own personality makeup which, as this study shows, depends mainly on the Pd scale on the MMPI. This to us seems of great practical importance and seems to contradict various lay conceptions such as, for instance, that a prison reforms only within the first 48 hours, while then it starts to deform. In other words, it is not the environment (in this case the prison), but it is the psychological makeup of the individual prisoner which determines his adjustment or maladjustment within the penitentiary. Furthermore, from the study it can be seen that the highest and most abnormal Pd scales were found among prisoners with the longest sentence, which, translated objectively, only points to the logical fact that their offense in the first place must have been more severe. Thus, a correlation between the severity of the crime and the abnormality of the Pd scale can also be made, which substantiated in general the findings of our former investigation in this regard.

This study also reveals that there is no direct c o r r e l a t i o n between the age of prisoners and their social or institutional adjustments, but again the importance of the personality profile was evident. In other words, all patients with a normal Pd profile, regardless of their ages, made a good adjustment; those with moderately abnormal Pd peaks a fair adjustment; and those with a markedly abnormal Pd peak made a poor adjustment. This study also confirms the findings, made previously, that the highest Pd peak is within the 26-30-year-old age group, which is further corroborated by the fact that the average age of prisoners within this particular institution is approximately 27 years, indicating that for all practical purposes more crimes are committed by members of this age group than by any other.

There is one fact which should be mentioned, namely, that the youngest age group (16-20 years) made a somewhat poorer adjustment compared with the other age groups; but this is felt to be partly due to the physiological changes of adolescence and late adolescence, and also partly due to the fact that in general only the most severe and incorrigible of the younger offenders are sent to a penitentiary rather than to a reformatory—thus again pointing to the importance of the Pd scale.

As far as the relationship between social adjustment and the number of crimes or types of crimes committed is concerned, this again confirmed the already established fact that the type of social adjustment is dependent on the p e r s o n a l i t y profile, especially the Pd factor, and not directly related to the number of crimes or the particular types of crimes committed. However, indirectly there appears to be some relationship since this study confirmed the findings of the previous study, namely (1) that repeaters or recidivists have a much higher psychopathic deviate (Pd scale) than first offenders, allowing the conclusion that the higher the psychopathic scale in a first offender, the more likelihood for him to become a repeater, and (2) that the mean personality profile on the MMPI of prisoners convicted of sex crimes is very similar to that of prisoners convicted of crimes of violence and both are distinctly different from that of prisoners convicted of non-violent crimes. Translated, this would

possibly indicate that persons convicted of sex crimes appear to be potentially persons likely to commit crimes of violence.

On the basis of this study then, the conclusion seemed justifiable that the most important factor, as far as the social or institutional adjustment of the individual prisoner within the penitentiary is concerned, is his own personality profile, especially the Pd scale as shown on the MMPI. This is found to be of great statistical as well as practical significance in predicting both intra- as well as extra-institutional prognosis. The social adjustment is not directly related to the length of sentence, to the age of the prisoner, to the type or number of crimes committed; it is definitely related, however, to the individual's personality profile and his own personality makeup.

The psychological or psychiatric adjustment of the individual prisoner within the penitentiary is also independent of the length of sentence, the age of the prisoner, the type and number of crimes committed; but it is dependent also on the personality profile as seen on the MMPI and in this case on the neurotic scales such as Hysteria, Hypochondriasis, Psychasthenia, etc., and in more serious cases on the Schizophrenia and Paranoia scales.

These findings have great practical implication both for the custodial as well as for the medical and psychiatric staff of the prison, since they can predict not only potential social maladjustment but also potential neurotic, psychosomatic and psychiatric disturbances; and this becomes even of greater practical significance when taken together with the findings of the previous studies, especially with the specific electroencephalographic patterns.

Obstacles To Prison-Inmate Therapy

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Sociology and psychiatry agree that development of delinquent behavior is a process rooted in the experience of early childhood; that no child is born delinquent, and there is no easy way to understand crime or criminals.

Any discussion of counter-forces in prison-inmate therapy cannot overlook the present mythmindedness in a scientific world, the persistence of "evil spirits," the M'Naughten Rules of 1843, the multitudinous pseudo-scientific "explanations" of criminal behavior, the acceptance of any one by those who foot the bills, will directly or indirectly impede such therapy.

The implications of psychiatric efforts may be hamstrung by psychiatrists themselves, for some members will sell their services to the highest bidder despite social consequences.[1] The inconsistency of psychiatric diagnoses rebounds to the embarrassment of the profession at large. Few judges or prison wardens are impressed by psychiatry.

Many inmates possess attitudes inimical to psychiatric therapy, due to previous conditioning by the law, the courts, the police, the prison, denial of parole, and the detainer.

Due to inconsistencies of judicial interpretation, sentences of inmates from sections of the same state may vary from three to twenty years for identical crimes. The professional criminal is hardly susceptible to psychiatric therapy, for presumably he is as satisfied with his profession as the psychiatrist is presumably satisfied with his.

Many special criminal offenders such as drug addicts, alcoholics, prostitutes, psychopaths, pyromaniacs, and the like are themselves victims as well as perpetrators of their compulsive drives. What kind of therapy is indicated in a prison setting for the above categories, who for the most part belong in a hospital? Unfortunately, American jurisprudence has failed to keep step with dynamic psychiatry, has decreed that one offender is a neurotic and not insane, while another may be a psychotic and therefore *ipso facto* not responsible for his acts.[2] Many if not most sex deviations are matters of legal terminology

with little or no relationship to reality situations.

Techniques of the "third degree" and "cleaning up the blotter" so freely used by law enforcement agencies cannot help but create uncooperative attitudes in the prison "patient." Adverse attitudes are reinforced through jail experience as the inmates are compelled to drag out the hours in a narrow cell or common pen, helpless against the inevitable filth, open toilets and odors of disinfectants.

Inmates who have been convicted unjustly cannot be expected to respond to psychiatric "treatment," as they become convinced that all talk of honor, integrity, and justice are at best but meaningless abstractions. Even to the guilty, the frustration and monotony of the prison are well known and the prison attempting to both reform and punish at the same time presents a challenge to any therapeutic program.

Despite a "clean record," only 30 per cent of prison inmates make parole. Denial of parole often begins the period in which the prisoner starts to lose faith. The detainer also operates against even the best rehabilitative program in the correctional process, as it kills what little hope convicts have.

The prison psychiatrist seldom enjoys the confidence of the inmate, who may refer to him as the "nut doctor" or "squirrel guy." The psychiatrist is identified with prison administration and officialdom and hence is another "natural enemy" of the prisoner. Due to the continual processing of new arrivals and those being discharged, the inmate, on an average, is not likely to receive more than two hours of psychiatric consultation during his entire incarceration.

Rehabilitation will continue to go by the board until the basic system is changed, that is, prevent criminals instead of preventing crime. The former eclectic approach is giving way to a more rigorous interest in a specific social psychological approach to human behavior, criminal and non-criminal alike. One encouraging feature of present-day research-leads is the posssibility that sociology and psychiatry, functioning together, may be able to work out a more complete theory of criminal behavior.[3]

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[1]Robert M. Lindner, *Stone Walls and Men*, New York: Odyssey Press, 1946, p. 140.

[2]Benjamin Karpman, "The Sexual Psychopath," *The Journal of Criminal Law, Criminology, and Police Science*, Vol. 42, July-August, 1951, pp. 195-198.

[3]Marshall B. Clinard, "Sociologists and American Criminology," *Journal of Criminal Law and Criminology*, Vol. XLI, January-February, 1951, p. 577.

The Quandary of Alcoholism

The burdening problem of alcoholism, in one or another of its many phases, is reflected in the news nearly every day. The tremendous cost, economic, moral and emotional, of this social incubus is well enough understood. It stands with war, the as yet incurable illnesses and mental disease as one of the great challenges of our time. Well-meaning efforts are being directed toward its amelioration. But insufficient attention has been given to the profound roots and complex implications of this and other addictions. Not until alcoholism is faced forthrightly, on the basis of its true diagnosis, as part of the long-range problem of general and basic mental health will its inroads be reduced, to say nothing of controlled. As a contribution to this point of view, the following extract from "Drink and the Devil, " a forthcoming book by Ralph S. Banay, M.D., is presented.

We have laughed and cried enough over the antics of the "drunk." From the time of "Ten Nights in a Barroom" to "Lost Week-End," "Harvey" and "Mrs. Murphy," the psychological appeal remains the same. Whether the stories amuse, amaze or shock, there is a puckish feeling of curiosity toward those who have shown a mischievous disregard for conventions and for maturity. Often there is a tendency to overlook the unpleasant effects beyond the naughty and defiant appearance of the over-indulged. Even the euphemisms of being "plastered" and "under the weather" indicate a humorous tolerance rather than serious concern. Somehow this feeling has got off the track; it would seem that the very suggestion of alcohol spreads an intangible aura that clouds objective perception with a deceptive glow, so that we tend to lose sight of the true significance of this personal and social problem and its complex implications.

The publicity given to group movements like Alcoholics Anonymous and its numerous imitators and offshoots has had the welcome effect of focusing public attention on the need for a rehabilitative treatment of alcoholics. There has been a flood of well-intentioned literature — from former alcoholics who profess to have been cured of the drinking habit, from persons who have helped heavy drinkers to combat their addiction, from sociologists, statisticians and others who have synthesized or romanced upon this increasingly threadbare material. From all sides has come a spate of confession, t e s t i m o n y , analysis and theory.

Unfortunately, not much of this material has intrinsic value. Those who have satisfied themselves by presenting their own modified case histories and deductions fail to expose the depth and breadth of the subject. Those who have entertainingly treated the light or episodic aspects of alcoholism's manifestations have ignored the fact that this is an issue that grows malignantly on the body of society. Those who purport to exhibit t h e m s e l v e s as high priests of resounding crusades can hardly be expected to advance their cause. All these contributions have their merits, yet virtually all of them are based upon the

fallacy that it is possible for relatively untutored laymen, equipped only with an experience in drinking, to lead alcoholics out of the morass of their difficulty.

Men of all walks of life, doctors, clergymen, social workers, family counselors, and others for whom the subject is of pertinent interest, continue to seek a concise and comprehensive presentation of the knowledge so far accumulated and the theories proposed for the evolution of an effective treatment. They are looking for the prism that will break down and bring into proper relationship all the confused elements of the spectrum of excessive drinking.

This volume represents an effort to contribute to the understanding of alcoholic addiction by weeding out subjectivity and the superstitions and misbeliefs that have traditionally clouded the topic; and to perceive the problem in its proper light as a complicated one that concerns not only the individual ensnared in it, but society at large, which bears the ultimate responsibility for meeting its challenge. What is the essential nature of alcoholism? How does it originate and develop? How can we bring the alcoholic — a gloomy, disillusioned, suspicious and elusive personality— around to the realization, tremendously difficult for him, that something is out of hand and that there is hope for him if he will accept help. Further progress toward answering these questions would be progress toward easing this perennial social burden. The endless quest for a "cure" for alcoholism has been carried out with many varieties of approach — the faith method, religious appeal, moralization, attempts to strengthen the will through suggestion or aversion, group action and others. Each of these methods no doubt has succeeded in prevailing upon some habitual drinkers to overcome their addiction, at least temporarily, but some of them tread on dangerous ground. The most common error is to set up as ends in themselves these homespun, non-rational techniques, which might serve as useful means. These endeavors fail because they are rooted in the mistaken notion that drinking is a habit that the individual has the power to control. This is true to a degree, but when that degree is passed the drinker is as helpless as a bit of flotsam in Niagara; he is a prey to the automatism of his addiction. Realistic, expert treatment is essential to implement the aim of re-establishing self-government. An associated error, which has tended to divert therapy onto sidetracks, is the confused misconception that alcoholism is a distinct pathological entity, whereas actually it is a symptom of an underlying and usually profound personality disorder.

Like addiction to narcotics or any other compulsive habit, alcoholism needs to be attacked with skill based upon extensive previous experience. Much remains to be learned, but clinical observation and progressive discovery continue to expand the equipment with which qualified experts offer hope of rehabilitation to the patient addicted to drinking. Meanwhile, the broader aspects of community-wide remedial action can be stimulated in other fields by increasing the comprehension and intelligence with which the problem is regarded by public opinion.

It is no wonder that our ancestors associated drunkenness and other aberrations with the malevolent powers of a devil. Anyone who has had experience with alcoholics knows that they are indeed bedeviled by something even worse than the diabolical creatures of vivid imaginations— worse because of its terrible actuality. The neurotic condition of the chronic drinker can and does assume a role fully as fright-

ening as that of a mythological monster, and the therapist, although his function is far from exorcism, feels at times as if he were grappling with forces hardly human.

Drinking is a firmly established, highly cherished social custom. In spite of the vigorous prohibitory efforts of militant minority groups, it cannot be erased in our culture under any foreseeable conditions, even if that were thinkable as a remedy. A large proportion of the people of the world make a practice of drinking occasionally without considerable harm to themselves or others. There is even a reasonable case for the therapeutic value of alcohol: doctors and physiologists have asserted that, after a certain age, moderate drinking not only is permissible but can be beneficial—a counsel distilled in Osler's famous description of alcohol as "old men's milk."

The problem, therefore, is circumscribed: it concerns those persons who, for reasons inherent in their physical or emotional make-up, or acquired, cannot drink without becoming enmeshed in a habit. Who those people are, why they are so disposed, how they can escape from their incubus and how others can be prevented from falling into the same whirlpool — that is the scope of this discussion. On the periphery of that undertaking we come to the need for a form of adult education for all men and women, but especially doctors, parents and teachers, who may be called upon to advise or assist people in distress. Perhaps, too, we may learn in time so to condition our homes and the other circumstances of life as to eradicate gradually some of the factors that combine to encourage or engender alcoholism.

Armed with, adhering to and utilizing the knowledge we now possess, and continually alert for more effective techniques, we can make sizable inroads upon the ravages of alcoholism and prevent needless human sufferings, tragedies, illnesses and crimes.

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Vandalism and Its Roots

Vandalism by children and adolescents has become increasingly conspicuous as a symptom of social pathology. Malicious wrecking of school premises, willful burning of schools, attacks upon and intimidation of teachers, destruction of publicly-owned installations in streets and parks, damage to public conveyances, defacing of meeting places and private property, even the desecration of churches—this disquieting spoor of contempt, defiance and aggression toward symbols of established order had no sizable counterpart in the remembered childhood of most of today's adults. What is its cause? How can it be faced and understood?

The malaise is too wide and too deep to be written off merely as part of the turbulence of the atomic age. Its roots are many and diverse; some of them must be recognized as errors of commission and omission on the part of parents and others in authority, others have grown from fads and foibles that deflect and weaken our grasp upon the fundamental problems of life.

One of the main sources of this trouble would seem to be the importance assigned to the unearned increment of life's rewards. Never have children had so many advantages, never have they been so surfeited with comforts, luxuries, amusements and, if they would use them, of the means of education. In their anxiety to spare their children the labors they knew, parents have all but forgotten that hard-won fruits are dearest. Home work, to say nothing of home chores, has become rare or negligible. Some colleges do not even require students to attend lectures. Youngsters expect to have the use of a car, if not their own "hot rod." They must be dressed in the height of fashion. When every day is Christmas and jackpots are a common occurrence, can a boy or girl be blamed for becoming blasé and demanding more and more? But is this an effective preparation for either a serene or a competitive life?

How much of this is Mom's fault? It would be unfair to indict all mothers with the stigmata of Momism. Yet it is undeniable that the archetype of female domination and overpossessiveness is all too common. She coddles and indulges the children, anticipating their every whim. She masks the matriarchy of the family structure by invoking the father-figure as a symbol of mythical discipline, while preserving her own perquisites as the loving giver of all. Her standards of judgment are based more upon rivalry with the neighbors or what is modish than upon the eternal verities. She unwittingly fosters femininity in her sons and masculinity in her daughters. She fails in the duty of inculcating respect for parents and the hearth as the basis for adaptation to the outside world.

How does Dad figure? All too often the standards of the family existence are so inflated, with unnecessary needs outracing resources, that he is too immersed in the struggle for money to play the full role of father. So he abdicates, permitting Mom to rule. If he exerts a masculine influence on the home, it is limited by his workaday fatigue and depletion.

One old enough to remember a less addled world is struck by the decline of true masculinity. Not only have masculine force, vigor and integrity been adulterated, but traits most commonly observed lack the timber of male positiveness. Consider, for example, the prevalence of exhibitionism; in dress, manner and social adaptation men and boys have become more feminine. Is this rivalry with, or acquiescence to, the female influence?

Where are the heroes of old? When literature and drama were the main sources of inspiration and entertainment, boys set up as their ideal some real or fictional figure suffused with robust idealism. With whom do today's youngsters identify themselves? Usually it is some swashbuckler of the vanished frontier or the neurotic protagonist — or victim — of a whodunnit. Death is the child's constant companion, so the phantasies of his play are concerned with killing or other violence. Destruction is the theme. The prevailing so-called literature, whatever its content, is luridified with covers magnifying sex and sadism. The old-fashioned bookstore is going the way of the old-fashioned theatre.

The growth of a child is a product of the interplay of repressive and permissive elements. It is axiomatic that when rapport is established between what should be controlled and what may be permitted, the personality is shaped for wholesome existence in a gregarious society. Somehow that process has jumped off its familiar track. A child's spontaneous cruelty or destructiveness, as in dissecting a fly or taking a clock apart, is prompted by natural curiosity; but an adolescent who continues to act on that level is simply failing to mature into adult responsibility. The tendency of youth toward violence, destructiveness and iconoclasm connotes a fixation on the primitive level. Can it be a response to the glorification of the subconscious that is so evident in the molding of public taste? Movies and television join the other mass-media in a conspiracy to create a mass demand for the superficial, the meretricious—and the primitive. It may be significant that even among collectors of antiques there is a vogue for the primitive that transcends the quest for mere beauty.

The classical concept of aggression defines it as a product of frustration. Aggressive tendencies are not always destructive; controlled and directed, they may be part of the daily process of overcoming life's obstacles. Only when they explode as an anarchic remedy for unbearable anxiety do they become malignant. We know, too, that a large part of juvenile delinquency is simply the d r a m a t i c signal by which youngsters call attention to their psychic distress. There is reason to believe that the current forms of youthful vandalism are similar symptoms—criteria of the youths' subconscious dissatisfaction with their environment. They are expressing resentment against frustrations too profound and complex to be self-understood.

Vandalism, like delinquency, will never be cured by indignation. The solution to the problem lies, not in reforming youth, but by looking searchingly at the world in which it must live.

Our Counterpart In Japan

It is gratifying to discover that this association has a flourishing counterpart in Japan. The Correctional Medical Association, with headquarters in Tokyo, may be considered a pioneer project, since it was established in 1925 as the Association of Prison Hygiene. After a wartime interruption it was re-established in 1951 with its present name. Traditionally associated with the medical division of the Ministry of Justice, it is a private organization interested in coordinating such sciences as medicine, psychiatry, psychology, pedagogy, sociology and statistics with the double aim of treating and returning offenders to society and studying crime with a view to its prevention.

We are indebted to Masao Otsu, president of the Association, for an impressive description of its work as well as a fraternal greeting to our members as collaborators in a common cause. The Japanese association's officers, directors and counselors include more than thirty eminent university professors, government officials, prison and other institutional doctors, as well as leaders in medicine, psychiatry and associated disciplines. The membership is about 500 and a quarterly journal is published.

A list of subjects on which the Association's members have prepared studies indicates the scope of the work under way. These include: Social aftercare of prisoners, sexual life and psychogenic reaction under confinement, influence of prison work on health and fatigue, reaction concerning neurosis under confinement, influence of operational aggression, measurement of fatigue in prison work, electro-encephalographic diagnosis of delinquents, study of twin offenders, and psychopathology of habitual delinquents.

Data supplied by Mr. Otsu indicate a large segment of medical correctional work in Japanese institutions. Of 176 correctional institutions with a population of 87,229, five are medical reformatories (for feebleminded, mentally defective and tuberculous persons) with 780 inmates, and three are medical prisons (for physically and mentally defective and leprous patients) with 822 inmates. Among 296 institutional physicians, fifty are psychiatrists. Inmates appear to be strictly classified by age, physical and mental condition and potentialities for rehabilitation, and assigned to appropriate institutions accordingly. Mental hospital facilities are being expanded to accommodate the large proportion of mentally defective and psychotic cases among offenders.

A comparison of the Japanese Association's constitution with our own suggests that its general aims and objectives are much like ours. The principal difference would seem to be its close degree of association with the national prison system, a condition naturally to be expected under Japan's traditional paternalistic-authoritarian regime.

This purview of Japanese correctional endeavor may be interpreted with special interest in connection with the review of Dr. Moloney's book, "Understanding the Japanese Mind," which appears elsewhere in this issue.

BOOK REVIEWS

UNDERSTANDING THE JAPANESE MIND, James Clark Moloney, M.D., Philosophical Library, New York, 1954.

The Japanese are neither mysterious, inscrutable nor unpredictable, as is popularly supposed, but are reasonable, understandable and predictable when one comprehends the restrictions placed upon their individual and collective behavior by a rigid matrix of tradition.

Dr. Moloney, a Michigan psychoanalyst who was a psychiatric consultant in the occupation forces in Tokyo, bases his conviction upon his study of Japanese anthropology, history, sociology and religion. His thesis is that the Japanese behave differently from all other humans; that, conditioned by a family and social system that was medieval, feudal and hierarchal until eighty years ago, their racial group has maintained its essence, character and form almost unbroken since prehistoric times, and that their individualism has been so repressed and their collective nationalistic entity so mobilized and exploited that the Japanese "not-to-be-free" cultural concept is basically antithetical to the Western concept of individual freedom.

As a key to and illustration of his conclusions, Dr. Moloney offers the theory that the surprise assault on Pearl Harbor in 1941 was a time-fuse explosion of the national hatred and resentment planted by an American "sneak attack" nearly a century before. Commodore Matthew Perry, in the name of President Fillmore, opened Japan to Western trade with a show of force in 1853 and Townsend Harris implemented this humiliating "invasion" with further pressure a few years later. Projecting this idea in current terms, Dr. Moloney asks what we may eventually expect in return for the desolation of Hiroshima by the first atomic bomb.

Japan's mystical national character is founded upon the concept of coevality: Nippon always was and always will be, the imperial throne is coeval with heaven and earth, and the past and future are united in the present. The Emperor, both divine and mundane, combines the attributes of a revered father and a good mother—the symbols upon which the family and hierarchal systems are based. The child's status in the family and in society is determined at birth. From his infancy cultural pressure is applied to make him conform to a predetermined pattern and throughout life the regime insists upon his disindividualization. The insignificance of the individual, in a cosmos where earthly life is treated as a transitory interval, is the transcendent idea.

Women are inferior, unprivileged members of the family, yet Dr. Moloney finds a key significance in the mother's role. The mother-child orientation is intimate and warm, as exemplified in the practice of carrying the growing infant in a sling on the mother's back—a skin-to-skin relationship that leaves no childhood need to turn to the self for gratification. The "good mother" element is strong and the "bad mother" factor is deflected to the father. However, the infant is trained to bow to the father, who, like the Emperor, is protected by taboos. Rigid child-training de-

stroys the rights of the individual and the frustration of personal striving produces fear and rage. Spontaneous expression of this rage is inhibited; it is loosed only upon acceptable targets. Thus hostility is internalized or repressed. This is said to account for the fabled Japanese equanimity in the face of affront or insult and for a shrinking from individual decisions that reduces the sense of personal responsibility.

A remarkably low rate of institutionalized insanity and the relative infrequence of paronoid psychosis are related to the cultural pattern, which makes the male virtually incapable of individually sponsored aggressive behavior. Female psychopathology is more outspoken, but most cases of mental disturbances are tractable enough to be kept at home. However, high rates for allergy, apoplexy and suicide reflect the turbulence resulting f r o m culturally-imposed repression. The traditional national games and plays are noticeable as outlets for pent-up hostility. Military men inherit the privileges of the Samurai warriors of old. It was they who mobilized the ingrained trait of mass compulsive obedience to authority in Japan's attempt at world conquest. The cruelty and high-handedness of Japanese troops, loosed under the sanction of a national semi-religious crusade in an extra-national dispersal of hate, would be rare or unthinkable in person-to-person relationships. It is believed also that a psychological process of identification with the enemy explained much of the Japanese soldier's fanatical fury.

The familiar Japanese flair for copying is presented as a key trait. The accoutrements and gadgets of Western civilization multiply phenomenally almost as soon as they are introduced. Superficial verbalistic imitations of democracy, and duplication of American fashion and mass-cultural elements, are found everywhere. Dr. Moloney decides that this process has been applied to psychiatry, with particular reference to psychoanalysis. The influx of Freudian and associated doctrine was under way long before the war. He could not believe that the implications of psychiatric therapy ever had full sway in a totalitarian nation whose Bureau of Thought Control arrested 60,000 persons for "improper thoughts." His deduction is that psychiatry, like many other foreign manners, ideas and doctrines, has been syncretized; that is, assimilated, but made compatible with, rather than in conflict with, Japanese ways. He suggests that feudal Japan's e m p h a s i s on in-group characteristics survives in an atmosphere of exclusiveness, cliquism and hostility to outsiders, and that imported psychotherapy has been adapted to fit the prerequisites of the cardinal principles of a persistent national entity.

THEY WENT WRONG, Crosswell Bowen. McGraw-Hill, New York, 1954.

Mr. Bowen has come into prominence as a crime reporter who dissects violent behavior on the personal and sociological levels. His articles in the New Yorker and other magazines, of which this book is composed, are based upon his knack for winning the confidence of people in trouble and setting down the environmental and emotional circumstances of their offenses. He tells the stories of a hold-up-killer, a mixed-up youth who took his young sweetheart on a cross-country spree of murder and robbery, a sadistic policeman, a city-street gamin living on the fringes of crime, a quasi-intellectual who set out to be a fascist, and a prison-stunted convict turned

loose in a bewildering world after serving nineteen years.

The principal value of Mr. Bowen's sketches would seem to lie in their power to let one see the accumulation of personal problems and conflicts that leads up to the triggering of murder. His formula combines the fascination of crime narrative with a sympathetic approach to the underlying factors. The social sores that fester at the roots of crime are implicit in his mainly factual exposition. However, he falls short of revealing a full insight into the crucial relationship between the kind of crime with which he deals and mental pathology: that is, the psychogenic factor.

The superficial way in which Mr. Bowen skirts the root of the problem is illustrated by his attention to the youth's human need for joining a group. Citing the Skull and Bones fraternity at Yale as an example of purposefully channeled gregarity, he suggests that a sort of perversion of this joining impulse throws young people into corrupting associations. So far, so good. But it is essential to ask what it is, besides restricted opportunity, that pushes potential delinquents into infectious company. Probing into this complex of causation, one finds almost invariably that a youngster's crossing of social taboos results from the thwarting of profound tendencies and needs. The youth who "goes wrong" is unaware of the goad that has made him antisocial; but it has been shown repeatedly that behind every perverted quest for satisfaction is a frustration that might have been prevented, or at least compensated in an acceptable way, somewhere along the trail of familial and social relationships. In addition, one must consider the many varieties of psychic and somatic pathology that may contribute to these aggressions. It is so important, in serving the long-range objective of wholesome emotional education, to see this problem whole that it is obstructive and misleading to concentrate upon symptoms when the disease cries out for cure.

MUSIC THERAPY, edited by Edward Podolsky, M.D., Philosophical Library, New York, 1954.

Anyone unfamiliar with the esoteric ranges of medical literature may be surprised to learn not only that music therapy is firmly established but also that it has been brought under so extensive a system of definitive control. This stimulating anthology collected by Dr. Podolsky, a psychiatrist in Kings County Hospital, Brooklyn, envisages selected and prescribed music as an adjunct of pharmacology and an adjuvant of both somatic and psychiatric medicine in the treatment or amelioration of a wide scope of illnesses and disturbances.

One is especially impressed with the record of progress here disclosed in the experimental use of music therapy in public and private mental hospitals. From the routine playing of music in wards and common rooms, as well as group singing and orchestral and band concerts, to musical backgrounds for electroshock and other therapy, the judicious administration of this aural drug is shown to be singularly effective. In such trying episodes of treatment as minor or local-anaesthetic surgery, an aura of melody also often is useful as a palliative for the patient's anxiety and tension.

Among the forty contributors to this collection are many who have empirically determined what types of music best serve specific purposes. The classified lists of selections so adduced should be useful to practitioners or institutions employing music's aid for the first time.

As Dr. Podolsky and Dr. Ira M. Altshuler explain, music therapy is no modern discovery. Confucius and the ancient Greeks recognized the relationship between music, natural rhythms and harmonious living and suggested the therapeutic value of spiritual and sensual enjoyment of tonal assonances. The revival and extension of this principle happens to coincide opportunistically with the "hi-fi" vogue, but one may expect that its benefits will be integrated in medical practice with lasting rewards.

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